CMS-RHT-26-001

Rural Health Transformation Program

Application Submission from the State of Vermont

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Acronym List

Acronym	Full Spelling
AAP	Adults' access to preventive/ambulatory health services (HEDIS measure)
Act 167	Vermont Act 167 (2022)
AHEAD	Achieving Healthcare Efficiency Through Accountable Design
AHS	Vermont Agency For Human Services
AI	Artificial Intelligence
APCD	All-Payer Claims Database
APRN	Advanced Practice Registered Nurse
CAHs	Critical Access Hospitals
CBP	Controlling high blood pressure (HEDIS measure)
CCBHC	Certified Community Behavioral Health Clinic
CHF	Congestive Heart Failure
CLIA	Clinical Laboratory Improvement Amendments
CME	Continuing Medical Education
CMS	Centers For Medicare & Medicaid Services
CON	Certificate of Need
COPD	Chronic Obstructive Pulmonary Disease
CRNA	Certified Registered Nurse Anesthetist
CY	Calendar Year
DA	Designated [Mental Health] Agency
DFR	Vermont Department of Financial Regulation
DSH	Disproportionate Share Hospital
DVHA	Department of Vermont Health Access
ED	Emergency Department
EMR	Electronic Medical Record
eCQM	Electronic Clinical Quality Measure
EMS	Emergency Medical Services
EMT	Emergency Medical Technician
FFY	Federal Fiscal Year
FTE	Full-Time Equivalent
FQHC	Federally Qualified Health Center
FUA	Follow-up after ED visit for substance use (HEDIS measure)
FUM	Follow-up after ED visit for mental illness (HEDIS measure)
GCRSA	Governor-Certified Rural Shortage Area
GMCB	Green Mountain Care Board

Acronym	Full Spelling
GSD	Glycemic status assessment for patients with diabetes (HEDIS measure)
HEDIS	Healthcare Effectiveness Data and Information Set (developed by the National Committee for Quality Assurance)
HFY	Hospital Fiscal Year
HPSA	Health Professional Shortage Area
HRIS	Human Resources Information System
HRSA	Health Resources and Services Administration
HSA	Health Service Area
HVAC	Heating, Ventilation, and Air Conditioning
IMLC	Interstate Medical Licensure Compact
IT	Information Technology
LNA	Licensed Nursing Assistant
MH	Mental Health
NP	Nurse Practitioner
OBGYN	Obstetrician-Gynecologists
PA	Physician Assistant
PCR	Plan all-cause readmissions (HEDIS measure)
PMPM	Per Member Per Month
RHC	Rural Health Clinic
RHT	Rural Health Transformation [Program]
RN	Registered Nurse
RPM	Remote Patient Monitoring
RSA	Rational Service Area
SFY	State Fiscal Year
SNAP	Supplemental Nutrition Assistance Program
SPRY	State Plan Rate Year
SSA	Specialized Service Agency
STLDI	Short-Term, Limited-Duration Insurance
SUD	Substance Use Disorder
USDA	United States Department of Agriculture
UVMMC	University of Vermont Medical Center
VHIE	Vermont's Health Information Exchange
WCV	Child and adolescent well-care visits (HEDIS measure)

Project Narrative

Rural Health Needs and Target Population

Background and the Case for Transformation

For a small, rural state, Vermont has a well-established health care system, nearly universal insurance coverage, and a robust set of health reform initiatives planned or underway. However, Vermont, like other states, is facing a rural health care crisis. In 2022, Vermont passed a law (Act 167) to request development of a report summarizing the state's health care problems, many of which affect rural communities more than others.[1,2] Through this historic opportunity, the state seeks funding to address the key challenges identified by Act 167 and ongoing stakeholder feedback:

- Health insurance costs and out-of-pocket limits have gone up significantly over the past ten years.
- Vermont's health insurers are facing financial sustainability issues. Claims have far exceeded premiums in recent years, requiring them to use reserves at an unsustainable rate.
- More than half of the state's hospitals are operating at a loss and experiencing financial distress.
- Vermont is experiencing a housing crisis, which is contributing to significant health care workforce shortages.
- Vermonters are experiencing long wait times for primary and specialty care.
- There are gaps in community-based care that result in increased use of hospitals.
- People with low incomes in rural areas have a hard time getting health care and often need help with housing and transportation.
- The state is experiencing a rise in adult and youth MH and SUD needs and is facing challenges meeting demand for services.

- Though the state's labor participation rate is high, the overall population is aging, which places pressure on the health care workforce and the state's total cost of care.

Vermont's transformation plan, outlined in detail below, aligns with CMS's RHT Program strategic goals and will be informed by the state's prior work and planning. Ultimately, Vermont's vision for transformation is to ensure that rural residents have access to the right care, at the right time, in the right place, at an affordable cost.

Vermont's Criteria for Identifying Rural Areas

Vermont's State Office of Rural Health and Primary Care uses the HRSA Federal Office Of Rural Health Policy definition based on updated USDA Rural-Urban Commuting Area codes and Road Ruggedness Scales, updated as of Sept. 12, 2025.[3] This definition indicates that all locations in Chittenden County in the state of Vermont are considered non-rural for grant making purposes, while all locations outside of Chittenden County are considered "rural." Thus, nearly two-thirds of Vermont residents live in rural areas. Vermont recognizes that there are several different ways to define a rural area, which vary by source.

Key Vermont Demographic Information

Vermont's unique population demographics and health care delivery system characteristics informed development of the state's RHT Program vision and approach.

General Population Characteristics and Trends	• The current population in the state of Vermont is approximately 647,000 people, according to state Department of Health data from July 2024.[4] The 2020 Census indicates that Vermont's population density is 70 people per square mile, which is well below the national average.[5,6] For more information on population by town, county, and age/gender over time, please see **Supporting Documentation, Exhibit 1**. • Vermont has 14 counties and 255 towns and cities. People in Vermont are governed by the state and their local town or city, not by the county.[7] • According to July 2024 Vermont Department of Health data, more than one-quarter of people live in Chittenden County. Rutland and Washington counties are the second and third most populous. Caledonia, Essex, and Orleans, the counties that make up what is

	known as the "Northeast Kingdom," are some of the least populated and the most rural.[8] [9] • Vermont's population is aging. One in four residents are over the age of 60 (28% or 183,000 adults), making it the fourth oldest population in the country (the American Community Survey reports that the median age in Vermont is 43.9 years, and the national median is 39.2 years[10]). • Since 2001, Vermont has experienced a decreasing youth population.[11] • Adult physical and cognitive disability rates vary across the state. Counties in the Northeast Kingdom have more people with disabilities than other counties.[12] • Vermont's foreign-born population is lower than the national average (4.5% compared with 14.8%).[13] • 5.7% of residents are veterans.[14] • The state does not have any federally recognized tribal communities.
Income	The 2020 Census data reports that Vermont's median household income is $82,730 but rural counties report higher poverty rates (e.g., Essex, Windham, and Orleans).[15,16]
Employment and Unemployment	• 2020 Census data reports that Vermont's employment rate is 63% (higher than the national average: 61%). Health care is one of the most common industries in the state.[17] • As of August 2025, the Vermont Department of Labor reported that the overall unemployment rate is 2.5% (lower than the national rate: 4.3%). The civilian labor force participation rate was 65%. The unemployment rates for Vermont's 14 counties ranged from 2.4% in Addison and Chittenden Counties to 3.6% in Essex County.[18] Previous years demonstrate similar trends, with higher unemployment rates in rural counties.[19,20]
Education	Vermont residents have a high degree of educational attainment: 94% of adults age 25 and older have a high school education or more, and 42% have at least a bachelor's degree.[21] However, Essex, Orleans, and Franklin (all rural counties) have the highest rate of adults over 25 without a high school diploma.[22,23]
Transportation	Public transportation is limited or unreliable in many rural counties, particularly in the Northeast Kingdom and Rutland County.[24]
Broadband	80% of people living in rural areas in Vermont (outside of Chittenden County) have access to broadband, as do 85% of people in non-rural areas (Chittenden County).[25]
Housing	• Vermont has a long-standing, statewide shortage of affordable homes available to lower income households, which became more severe with the COVID-19 pandemic and resulting market shifts.[26] ○ Half of all Vermont renters are cost-burdened and one-in-four pay more than 50% of their income on housing costs, putting them at high risk of eviction.

	○ Renters at all income levels struggle to find an apartment. Vermont's rental vacancy rate of 3% is among the lowest in the country and well below the 5% rate of a healthy market. ○ Vermont has a per capita homelessness rate of 51 per 10,000 people, the second highest nationally. ○ Along with the rest of the country, construction of new homes in Vermont dropped to a low point following the Great Recession, with fewer than 1,500 homes statewide permitted each year in 2008–2012. ○ About 20,000 homes across the state have indications of housing quality concerns, according to 2022 Census microdata. ○ Compared to national averages, Vermont has higher rates of SUD and disability among residents in addition to a sizeable population of people older than 75 with mobility and independent living challenges. The state's limited supply of service-enriched housing struggles to meet these growing and complex needs.
Health Insurance	• 97%, or an estimated 621,700, Vermont residents are covered by health insurance. Over half of Vermont residents (52%) are primarily covered by private health insurance in 2025 (approximately 336,900 persons) while 23% are enrolled in Medicare and 19% Medicaid.[27] • 31% of the state's Medicare eligible population is enrolled in Medicare Advantage.[28] • Approximately 22,500 individuals were dually enrolled in Medicare and Medicaid in 2024.[29] • Approximately 32,000 people are enrolled in individual coverage through the state-based exchange (Marketplace coverage).[30] • Just 3% of Vermont residents reported no health care coverage (approximately 10,700 persons).[31] ○ The age group most likely to be uninsured is 25- to 34-year-olds—8% of Vermont residents in this age range are uninsured. ○ The income groups most likely to be uninsured are between 251% and 400% of the federal poverty line. ○ The uninsured rate is significantly higher in the Northeast part of the state (Caledonia, Essex, Lamoille, and Orleans Counties) at 6%, with Essex County having an uninsurance rate of 8%—far higher than the statewide 3%. • Health care affordability is a major challenge in Vermont.[32,33] ○ Both individual and small group market premiums have increased significantly between 2022 and 2025. For example, in the individual market, the average monthly premium has increased from $675 in 2022 to $1,049 in 2025 (55%); and from $591 in 2022 to $894 a month in the small group market (51%).[34] ○ State residents have experienced a 100% increase in plans' out of pocket maximums in the past five years.[35]

	○ A 2025 state survey revealed that many Vermonters, even those who are insured, delay care due to fears of medical debt.[36]

Health Care Delivery System

People in Vermont can access health care services from providers across the state, and most of these providers accept Medicaid patients. The table below summarizes the state's health care delivery system.[37,38]

Category	Total	Rural	Non-Rural
Academic Medical Centers UVMMC has the largest market share in the state (~50%).	1	0	1
FQHC*(11 FQHCs operating over 50 primary care sites)	70	61	9
Skilled Nursing Facility	34	29	5
RHC*	10	10	0
Home Health Agency	9	8	1
CAHs**	8	8	0
Psychiatric Hospital***	2	2	0
Ambulatory Surgical Center	2	0	2
Veterans Affairs Hospital	1	1	0
Notes: *Vermont's FQHC sites and RHC sites have facility-based HPSA designations based on specific criteria for their defined service areas. **All Vermont's hospitals are not-for-profit. The state does not have rural emergency hospitals. ***Vermont has six "Designated Hospitals" that have inpatient psychiatric units.[39]			

There is an extensive system of health and social services throughout the state offered by community organizations. Vermont's AHS supports statewide coverage of these services through 12 local health district offices. Vermont also has an interstate relationship with Dartmouth Health in neighboring New Hampshire, and both Dartmouth and UVMMC have strong medical education programs.

Vermont was selected by CMS to participate in the AHEAD Model (Cohort 2), which will hold participating states accountable for controlling overall growth in health care expenditures and

improving population health outcomes.[40] The primary components of the model are (1) state accountability for reducing growth in total cost of care for health care services, increasing investment in primary care, and improving health care outcomes; (2) Hospital Global Budgets, where hospitals will be paid a fixed amount of revenue to provide services to Medicare fee-for-service beneficiaries. Hospital Global Budgets will provide predictable funding and a basis to keep small rural hospitals open while they retool to meet modern challenges; and (3) Primary Care AHEAD, which is a voluntary program for primary care practices to receive an additional payment from Medicare to provide coordinated care to Vermonters.[41] As will be discussed further in this application, Vermont's participation in AHEAD is a sustainability factor for the state's RHT Program funding initiatives.

Certified Community Behavioral Health Clinics

Notably, Vermonters can receive care from state-specific MH and developmental disability providers, called DAs and SSAs, respectively.[42] While the state's DAs and CCBHCs provide similar services, not all DAs are CCBHCs.

The state has two CCBHC entities. (For more detailed information on active sites of care for both entities, see **Supporting Documentation, Exhibit 2.**) These sites do not have any formal contracts, called Designated Collaborating Organizations, as part of their CCBHC services. The current sites are not expected to grow significantly over the next five years.

On July 1, 2026, the state plans to certify the following organizations as CCBHCs if sites meet the required certification criteria:

Name	Address
Health Care and Rehabilitation Services	390 River Street, Springfield, VT, 05156
Howard Center	102 South Winooski Ave, Burlington, VT, 05401
Northwest Counseling and Support Services	107 Fisher Pond Road, St. Albans, VT, 05478
Northeast Kingdom Human Services	181 Crawford Farm Road, PO Box 724, Newport, VT, 05855

Name	Address
Washington County Mental Health Services, Inc.	885 South Barre Road, Barre, VT, 05670

Medicaid DSH Payments

There are 14 Vermont hospitals (not including psychiatric hospitals). 13 of these hospitals received a Medicaid DSH payment for the most recent SPRY, SFY 2024 for FFY 2025 (10/01/2024–09/30/2025), as defined at 42 CFR 455.301: Brattleboro Memorial Hospital, Central Vermont Medical Center, Copley Hospital, Gifford Medical Center, Mt. Ascutney Hospital, North Country Hospital, Northeastern Vermont Regional Hospital, Northwestern Medical Center, Porter Hospital, Rutland Regional Medical Center, Southwestern Vermont Medical Center, Springfield Hospital, and UVMMC.[1] Grace Cottage hospital, Vermont's smallest hospital, a 19-bed hospital specializing in serving patients with acute, rehabilitative, and palliative care needs, is the one remaining hospital ineligible for DSH.

Health Care Workforce

Over 3,000 physicians (~1,400 FTEs) provide patient care in the state (30% of FTEs are primary care).[43] Further, there are nearly 400 dentists in Vermont (300 FTEs).[44] More health care workers in Vermont work in rural areas (60%) than in non-rural areas (40%).[45,46,47]

Vermont has only a few RSAs (specific counties or groups of towns) that meet the federal criteria to qualify for designation as a HPSA: Brighton and Ludlow.[48] RSAs that currently qualify for GCRSA designations are Hardwick, Brighton, Newport, and Castleton RSAs.[49]

Despite these facts, the state has been experiencing a shortage in its health care workforce for nearly a decade and faces challenges employing physicians to balance population densities in many of its counties, especially in the Northeast Kingdom, the most rural region of the state. A

[1] Consistent with 42 United States Code 1396a(a)(13)(A)(iv).

2018 study found that while Chittenden County had a surplus of practicing practitioners, counties such as Essex, Orleans, Caledonia, and Lamoille had no more than 2–5 primary care sites available to the public.[50] Further, the state predicts that the supply of primary care physicians is 370 FTEs short of what the state will need in 2030 (112 short in family medicine, 190 short in internal medicine, 52 short in OBGYNs and 2 short in pediatrics).[51] The state also has a shortage of nurses[52] and MH/SUD practitioners.[53]

Health Outcomes

Data shows that people living in rural Vermont have worse health than people in other areas.

Chronic Conditions	• Rural Vermonters experience higher rates of chronic disease burden, including hypertension, COPD and other conditions.[54,55,56,57] • Counties in the Northeast Kingdom as well as Rutland and Bennington have higher rates of adult obesity.[58]
Dental	• Counties in the Northeast Kingdom have higher rates of older adults who have lost all of their teeth.[59]
Maternal and Child Health	• In general, women in Vermont have a very low vulnerability to adverse outcomes due to the availability of maternal health services.[60] • Vermont's child health outcomes show strong support in the state for early childhood and maternal health, with data highlighting recent improvements in breastfeeding rates, access to healthy food through the Women, Infant, and Children's program, and prenatal care.[61] However, some rural counties report access to care challenges.[62]
MH and SUD	• The rate of suicide deaths in Vermont is 19 per 100,000 people, which is higher than the national average (14.1 per 100,000 people).[63,64] • The opioid-related death rate is higher in Vermont than the national rate.[65] • Less than half of people began treatment for alcohol related conditions within 14 days of diagnosis in the state.[66] • Rural areas face elevated suicide rates[67,68], depression[69], and opioid-related adverse outcomes.[70,71] • Like other states, Vermont is experiencing a youth MH crisis, with significant prevalence and increasing incidence of depression and anxiety among youth and adolescents.[72,73,74]
Life Expectancy	• Residents of rural counties in the Northeast Kingdom and southern counties of the state live approximately 2–5 years less than residents living in non-rural Chittenden County.[75]

Health Care Access in Rural Areas

In many rural areas, Vermonters face barriers to care:

- Vermonters that reported long wait times to access care said that they experienced physical and psychological pain and declines in overall health as a result.[76,77]
- According to recent mapping of urgent care locations and drive times, Essex County experiences the longest drive times (over an hour). For MH urgent care specifically, drive times are longest in Essex, Windsor, and Rutland Counties for youth and Essex, Windham, and Bennington for adults. (See **Supporting Documentation, Exhibit 3** for more information on drive times, including drive times to hospitals, which demonstrate similar patterns.)
- Mapping of primary care practices by RSA shows differential access to primary care practices across the state. The counties with the fewest provider FTEs to 100,000 residents are Essex, Washington, and Windham Counties. (See **Supporting Documentation, Exhibit 4.**)
- Though annual physical check-up rates are similar across the state (ranging from 69% in Windham County to 74% in Franklin County), dental visit rates within the past year are lower in Rutland, Windham, and Bennington Counties.[78]
- Studies found that both emergency and regular transportation are often late or unreliable, making it hard for people to get health care.[79]

Financial Health of Rural Facilities

The Act 167 report and other state data highlight the financial vulnerabilities providers face in Vermont:

Hospital Closures	Vermont has not experienced recent rural hospital closures, but several facilities are at risk. Nine of the state's 14 hospitals reported operating losses (up to -8.9%) in 2023. Trends are projected to worsen with 13 of the 14 hospitals expected to report losses by 2028.[80,81] The state has provided

	emergency financial relief to a number of hospitals at risk of closure in recent years (e.g., Gifford Medical Center, Brattleboro Retreat, and Springfield Hospital). More information on the finances of Vermont's hospitals is available in the **Supporting Documentation, Exhibit 5** of this application.
Utilization and Patient Volumes[82]	• In 2022, there were a total of 238,919 visits to Vermont hospital EDs that did not result in admission to the hospital. • The state had a total of 140,554 outpatient visits in 2022. • Statewide, approximately 13% of total inpatient discharges were for out of state residents (New York accounted for 9%). Discharge counts vary widely by hospital/region.
Workforce Costs	Rising labor costs and difficulty recruiting providers have strained rural facility budgets.[83] As noted above, housing shortages have also created barriers to workforce recruitment and retention. For example, Vermont's Psychiatric Care Hospital has been unable provide staffing for beds lost during the COVID-19 pandemic and is experiencing workforce vacancy challenges that require reliance on costly travel nursing staff.[84,85]

Geographic Areas of Focus

Vermont envisions that RHT Program funds will benefit all hospitals, health clinics, and community health centers in rural areas statewide. However, several rural high-need counties are of particular focus: Essex, Orleans, Caledonia, Windham, Bennington, and Rutland.

Rural Health Transformation Plan Overview

Vermont's RHT Plan uses work from past years to identify the state's main health care problems and set goals for improving health care. Vermont has set concrete goals and a comprehensive approach for how to leverage this funding opportunity. These goals include:

1. Strengthening Vermont's Rural Health Care Workforce;
2. Increasing Access to Timely Care Across Rural Communities; and
3. Leveraging Innovative Strategies to Increase Quality and Reduce Health Care Costs.

Vermont's RHT Plan, as enacted through the initiatives supported by RHT Program funds, will transform rural health in the following ways:

Element of Transformation	Vermont's RHT Plan Activities
Improving Access	• Expand access to high-quality, affordable care across Vermont's rural regions by realigning services to ensure residents in rural areas can obtain care closer to home, including through strengthened community-based and non-hospital-based options. • Advance regionally coordinated service planning to better match provider capacity with population health needs, while maintaining timely access to care for all state residents. • Support expanded access to care through urgent care centers, mobile units, and home-based care models to reduce reliance on hospital EDs and improve timeliness of care. • Leverage telehealth and e-Consult technologies to extend specialist capacity and ensure timely consultation for rural primary care and MH and SUD health providers. • Invest in existing facility improvements and equipment that enable providers to adapt to population health needs. • Enable data-informed policymaking through new transparency tools to address gaps in access.
Improving Outcomes	• Target measurable improvements in chronic disease outcomes by supporting evidence-based, proactive condition management, home-based monitoring, and care coordination for high-risk rural populations, such as dual eligibles. • Reduce avoidable ED visits and hospital readmissions through enhanced access to urgent care, post-discharge follow-up, and community paramedicine services that deliver timely intervention in the home and community. • Improve MH and SUD outcomes by integrating treatment into primary care and urgent care settings, ensuring earlier identification and ongoing management. • Improve maternal and child health outcomes by improving prenatal and postpartum access, care coordination, and continuity of care for women and infants in rural regions via regionalization efforts and performance payments to increase the capacity of primary care practices. • Empower primary care providers to practice at the top of their capabilities and enabling specialty care support, when appropriate, to deliver high quality care.
Technology Use	• Modernize Vermont's digital health infrastructure through interoperability and transparency projects. • Enhance cybersecurity protections to protect rural providers. • Expand the use of telehealth, RPM, and AI-enabled tools to support chronic disease management, preventive care, and administrative efficiency in rural and primary care settings.

Element of Transformation	Vermont's RHT Plan Activities
	• Facilitate adoption of emerging technologies among small and independent practices.
Partnerships	• Foster statewide and regional partnerships among hospitals, FQHCs, independent practices, MH/SUD providers, EMS, home health agencies, and community-based organizations through health care transformation planning. • Establish and expand operational networks and technologies that support shared services (e.g., EMR, analytics platform, telehealth and e-Consult infrastructure, and centralized transfer coordination) among providers to maximize economies of scale and reduce administrative costs. • Improve transportation timeliness, and to appropriate settings of care through new clinical partnerships and data tools. • Promote through all projects collaborative learning, information sharing, and transparent dissemination of data and best practices. • Leverage existing advisory bodies to provide a formal governance and decision-making structure to ensure provider, payer, and community representation in RHT Program implementation.
Workforce	• Expand access to financial incentives and on-the-job training for health care providers to increase rural placement and retention, particularly among young workers. • Invest in new training pathways (e.g., residency programs) to encourage the workforce to train and remain in rural practice settings. • Support shared human resources infrastructure to reduce barriers to recruitment and enable flexible deployment of staff across the state. • Expand provider scopes of practice (e.g., pharmacists operating in test-to-treat models, EMS triage and treat and community paramedicine, CRNA supervision waiver) and telehealth-supported collaboration to enhance team-based care and bridge primary and specialty care.
Data-Driven Solutions	• Develop user-friendly dashboards and data tools to monitor access, cost, and quality metrics, supporting transparency and informed decision-making by providers, policymakers, and the public. • Strengthen provider participation in statewide health information exchange and data-sharing networks to enable real-time coordination of care. • Support primary care practices' capacity for data-driven quality improvement through investment in analytic tools, risk stratification, and referral tracking systems.

Element of Transformation	Vermont's RHT Plan Activities
Financial Solvency Strategies	• Absent regionalizing services, reducing business efficiencies, and modernizing the system of care, it is likely that over the next five years Vermont will see significant erosion of health and social services. The RHT Program will allow Vermont to address dual affordability and access challenges to prevent this erosion. • Regionalization reforms will enable evaluation of service lines, development of centers of excellence, and facilitation of novel service delivery models that focus on prevention and early intervention. It will also right-size facilities and transition appropriate services to lower-cost community or home-based settings to ensure long-term sustainability. • Other initiatives in this Plan build financial resilience by supporting operational efficiencies through us of shared service platforms, workforce upskilling/pipeline development, and digital infrastructure investments.[2]
Cause Identification	• Vermont's rural hospitals face systemic challenges including low patient volume, workforce shortages, aging infrastructure, and high fixed costs relative to service demand. • Many rural facilities experience competition from larger systems, including those operating in neighboring states, threatening financial viability and local access to care. • Vermont's RHT Plan mitigates these risks by optimizing and diversifying services by region and making targeted facility investments that maintain essential care capacity while improving efficiency and quality of care. • Workforce and technology initiatives in this plan also address key operational drivers of instability, reducing reliance on expensive temporary staffing and enabling collaboration to produce efficiencies. • Through coordinated planning and shared governance, the state aims to right-size the rural health delivery system, preserve local access to essential services, and align community resources with population health needs.

Vermont's specific funding initiatives are described in detail below. For information on the budget and associated costs of each initiative, refer to the accompanying **Budget Narrative**.

[2] Separately, Vermont's hospitals are actively working on improving provider productivity with support from consultants.

Program Key Performance Objectives

By the end of the RHT Program period (FY 2031), Vermont's RHT Plan seeks to achieve the following program-wide key performance objectives relative to the state's overarching goals:

- Goal #1 - Strengthening Vermont's Rural Health Care Workforce: The aging workforce and declines in numbers of FTEs in key provider types, especially in rural areas, are a significant concern in Vermont. Key performance objectives include: 1) Reducing the rate of decline and achieving stability in select providers practicing in rural areas, as measured in FTEs and numbers of providers relative to the rural population (targets under development); and 2) Achieving increases in the number of people supported by health care workforce training and financial assistance programs (baseline is 276 people; target is 300 people).
- Goal #2 - Increasing Access to Timely Care Across Rural Communities: A cornerstone of improving access to timely care is ensuring that rural residents can obtain care closer to home, by increasing and strengthening home-based and community-based options. Key performance objectives include: 1) Reducing all-cause readmissions and/or ambulatory care sensitive ED visits (baselines and targets under development); 2) Successfully implementing one or more community-based options in each of Vermont's rural HSAs (options include community paramedicine, urgent care, pharmacist test-to-treat, mobile units, RPM, e-consults, and telehealth support); and 3) Increasing the number of Vermont hospitals with completed transformation plans (baseline is zero; target is all fourteen of Vermont's hospitals).
- Goal #3 – Leveraging Innovative Strategies to Increase Quality and Reduce Health Care Costs: Innovations in Vermont's RHT Plan are focused on ensuring that rural residents have access to the right care, at the right time, in the right place, at an affordable cost. Key

performance objectives include: 1) Improving quality of care for people with chronic illness; specifically, improvement in controlling high blood pressure for people with hypertension, depression screening and follow-up, and glycemic control for individuals with diabetes (see the **Metrics and Evaluation Plan** section below for specific baselines and targets); 2) Increasing the number of patients with complex health needs who are engaged with their primary care community health teams (baseline is an average of 26,800 per quarter in 2024; target is an average of 27,000 per quarter); and 3) Reducing the rate of growth in hospital operating expenses (baseline is 8.9% from HFY 2023 to 2024) and/or total cost of care (baseline is 10.3% from CY 2022 to 2023). Targets for these cost metrics will be determined after further analysis.

More information on the measures that will promote these objectives and baseline data is available in the **Metrics and Evaluation Plan** section below.

Initiatives and Use of Funds

***Initiative 1**: Regionalization and Innovative Care Strategies*

Description	While some services, such as primary care, are essential in every community, other services, such as orthopedics or specialized trauma care, need a higher number of patients to maintain staff expertise and deliver safe, high-quality outcomes. It can also be expensive for every provider to offer the same full range of services. In these circumstances, there is value in coordinating care at a regional or statewide level. Specifically, duplicating services where there is not enough demand creates inefficiencies, increases costs, and has negative impacts on quality of care. A key output of Act 167's investigations on health system sustainability and hospitals' financial health was a consensus that the state needed to implement strategic "regionalization" of health care services to address these issues.[86] The goal of regionalization is to make sure health care services are right-sized and optimally distributed in the state so that Vermonters can get the care they need, when and where they need it, and at a price they can afford. Regionalization works toward this goal by redesigning how clinical services are delivered at the local, regional, and state level based on analysis of population needs. The state's vision is that certain essential services are available in local communities, while other services are in either regional

	hubs around the state or, for the most complex care, a single location statewide. Regionalization protects access to care over the long term by ensuring non-duplication of services and redirection of resources to high-value, essential services. RHT Program funds will be used by the state to conduct detailed strategic planning and implementation of a transformed, regional system of care, which will ensure sustainable access to services in rural communities beyond this award. The state has already completed initial stakeholder engagement and discussions to inform this effort. In parallel with broader transformation work, Vermont also plans to use RHT funds to expand access to community-based care through urgent care and mobile units as well as invest in equipment such as dialysis units and ventilators to provide high-acuity services to nursing home residents. These investments support the goals of regionalization by ensuring that Vermonters have the foundational services they need in their communities.
Potential Use of Funds	The state's use cases for RHT Program funds as part of this initiative include: *Regionalization Planning and Implementation* • **Transformation, innovation, and regionalization support grants:** Support health care providers in adopting tactical regional care strategies that will shift appropriate services from hospitals to non-hospital settings and create regional hospital services or centers of excellence. Grants will be made by AHS to health care providers to support the implementation of regional care changes that sustain high-quality, cost-effective care for Vermonters, and the grants will primarily be provided to non-hospital providers to strengthen the continuum of care, encourage care delivery innovation, and better align services with population needs. AHS will allocate a proportion of grant funding to provider proposals to implement innovative care models in line with the state's regionalization and transformation goals (e.g., hospital-home health partnerships, regional workforce sharing models, maternity care network development). Grants may also be used to purchase tools and technical assistance to enable interoperability between EMR systems. Vermont will design the grant initiative to ensure that only permissible uses of RHT Program funds are allowed. • **Transformation analytics and support:** Hire a vendor(s) to gather and study data that will inform hospital and regional transformation planning over the next five years; and provide project management support. The vendor(s) will provide modeling to assess the impacts of proposed reforms on cost, quality, access, and sustainability across Vermont's hospitals and regions. Analytics support will be made available to hospitals and non-hospital providers to support transformation and regionalization efforts (e.g., identifying areas most

	in need of enhanced maternity care capacity). The selected vendor(s) will also support onsite transformation activities with providers throughout the state in alignment with Vermont's regionalization goals, including backend office support, efficiency studies, and other administrative functions that can be streamlined. The state may require the vendor(s) to provide project management or other transformation support to the other Initiatives in this application, as needed. • **Facility upgrades to support regionalization:** Support renovations or upgrades to existing buildings and equipment in hospitals and clinics, so they can better serve their communities. Investments may include HVAC and sewer system upgrades, reconfigured office or clinical areas, and other limited physical modifications to support service realignment, shared operations, and integrated care delivery envisioned under Vermont's regionalization strategy. • **Development of a statewide health care delivery strategic plan:** Cover costs associated with hiring a consultant to develop and implement a Statewide Health Care Delivery Strategic Plan for Vermont. The plan will provide a roadmap for health care delivery system reform and promote access to high-quality, cost-effective services across the system. Key elements of the plan may include a shared statewide vision, goals, and objectives; annual total cost of care targets and related spending targets for primary and preventive care; identification of the resources, infrastructure, and supports necessary for implementation/monitoring. AHS intends for this plan to build on prior transformation and regionalization initiatives to ensure a coordinated, data-driven approach to organizing and sustaining Vermont's health care delivery system statewide. *Innovative Clinical Services to Support Regionalization* • **Community paramedicine/Mobile Integrated Health model:** Establish a mobile integrated health care and community paramedicine model that uses specially trained paramedics, Advanced EMTs, and EMTs working under physician/NP oversight, to deliver protocol driven care in patients' homes, shifting care out of the hospital. A phased statewide rollout will establish the legal framework, pilot and refine care protocols, and expand to all regions with standardized data, training, and quality assurance infrastructure. Core services will focus on post-discharge and primary-care follow-up, with the flexibility to add modules for surgical recovery, substance use, or other locally prioritized needs. This project will also include changes to the EMS scope of practice and associated reimbursement model, such as flexibility to "triage and treat" in the community (see **Supporting Legislative and Regulatory Actions** below). • **MH and substance use urgent care expansion:** Support targeted expansion of urgent care centers to enable immediate, walk-in access to MH and SUD care as a lower-cost, community-anchored alternative to

	EDs. Investments in urgent care expansion will include minor renovations within the blueprint of existing buildings to improve service capacity. This project aims to create new and long-term access points to preventive care at the community level. • **Mobile units offering medical, dental, and integrated MH/SUD services**: Support mobile clinic units to provide medical, dental, and integrated MH and SUD services for remote areas in the state. Several of the state's DAs have already piloted the model and lessons learned will inform deployment of new mobile units to rural areas where schools and homes do not have the necessary supportive services available. Dental mobile units will deliver oral health services to schools and residential facilities. • **Improving availability and access to high-acuity services for nursing home residents including dialysis services and ventilators:** Provide funding support for new grants to providers to purchase dialysis and nursing home ventilator equipment. Dialysis access for rural skilled nursing facilities is an ongoing challenge, with transportation constraints complicating patients' treatment progress. Vermont currently has only one nursing home ventilator unit, located at the Pines in Rutland, which is insufficient to meet demand, and Vermont has no nursing home-based dialysis options. Funding would support new dialysis units to serve Vermont nursing home residents, and funds would be used to invest in a second nursing home ventilator unit to enable the state to double its capacity for this critical service. Funds would cover equipment installation for dialysis services with necessary upgrades to facility infrastructure to serve patients—the state will also consider a mobile unit in place of facility units based on review of business plans. This project will be particularly important for individuals dually eligible for Medicare and Medicaid to support their ability to receive long-term care within their communities. **Estimated Budget Range**: $300–$400 million total across the five budget periods (not inclusive of state administrative costs). See the **Budget Narrative** for more information.
Relevant CMS Use of Funds Categories	A, B, D, E, F, G, H, J, K
Main CMS Strategic Goal(s)	Make Rural America Healthy Again, Sustainable Access, Workforce Development, Innovative Care, Tech Innovation
Relevant Technical Score Factors	B.1, C.1, C.2, D.3, E.2, F.2

Key Stakeholders	AHS Interdepartmental Partners, Health Care Delivery Advisory Committee, Health Care Reform Oversight Committee, Hospitals, Health Systems, Community-Based and Long-Term Care Providers, Community-Based Organizations, EMS, Clinicians and Other Health Care Professionals, Patients.
Sub awardees/ Subcontractors	To be determined at a later date in accordance with state procurement rules.
Supporting Legislative and Regulatory Actions	Vermont plans to expand the authority of the Department of Health to regulate EMS agencies and personnel to provide community paramedicine. AHS will make regulatory changes and design a reimbursement model associated with expanding EMS's ability to "triage and treat" in the community without requiring transport to EDs (i.e., enabling triage in the field and transfer to an alternate location, such as an urgent care center). Additional scope of practice changes may be pursued during the course of the RHT Program period.
Sustainability Plan	Vermont's regionalization initiative is meant to be a permanent change in how care is organized statewide. The goal is to reduce waste from redundant and low-value services and to redirect those dollars to services that communities need. Regional and hospital plans built under the RHT Program will set a shared statewide plan that the state will use when it makes future investments, reviews hospital budgets, and updates the State Health Improvement Plan. Instead of funding duplicative capacity (for example, two hospitals trying to run the same low-volume specialty service), Vermont will move those dollars to higher-value uses such as preventive care, primary care, and MH and substance use treatment. Many RHT-funded activities—such as updating facilities, awarding targeted support grants, building regional strategic plans, or standing up urgent care—are one-time costs. These one-time investments are designed to yield permanent effects: more efficient operations, better access close to home, and stronger rural hospital finances. When writing regionalization plans, the state will examine whether service lines that are important to community health are financially sustainable. If certain high-value services are chronically under-paid and at risk of closure, the state will redirect savings from avoided low-value care to raise payment levels and keep those services open. Finally, lessons from the RHT Program will shape the next generation of Medicaid and Medicare reforms—including Vermont's work under the AHEAD model and future value-based payment arrangements that reward hospitals, EMS, and community providers for working together. By building permanent regional governance, shared analytics, and structured decision-making into state processes, Vermont will ensure that RHT

	investments produce durable gains in access, efficiency, and health outcomes well past FY31.
Impacted Counties	Statewide

Implementation Plan and Key Milestones for Initiative 1: Regionalization and Innovative Care Strategies

Stage	Timeline (FFY)	Activities	Milestones
0: Planning	2026	• Draft project charter and detailed plan for regionalization work • Identify staff roles, post and recruit positions, and assign personnel • Engage stakeholder advisory group • Develop partnership and procurement plans • Develop program guidance and application materials for grant programs • Develop project plans for implementation of community paramedicine, urgent care expansion, mobile unit deployment and dialysis/ventilator purchases	• Stakeholder advisory group (Health Care Delivery Advisory Committee) convened by October 15, 2025 • Post new staff positions by February 28, 2026 • Approval of project charter and project plans by April 30, 2026
1: Launch	2026	• Hire project staff • Convene stakeholder advisory group • Post requests for proposals and execute contracts for vendor support • Open grant application periods for provider grants	• Staff hiring and onboarding completed by June 30, 2026 • Contracts executed for Transformation analytics vendor support by January 30, 2026, and Statewide Strategic Delivery Plan Development by July 30, 2026. Other vendor

Stage	Timeline (FFY)	Activities	Milestones
			contracts execute by December 31, 2026. • Grant application period opened for grant program(s) by September 30, 2026 • Convene stakeholder advisory group at least quarterly
2: Implementation	2026 and 2027 (October 2025–September 2027)	• Convene regional transformation meetings with hospital leadership • Expand regional transformation meetings and workgroups to include non-hospital providers • Leverage analytics support and technical assistance to develop and implement transformation plans • Develop draft hospital, regional, and statewide transformation plans • Select and award applicants for provider grants (round 1) • Convene stakeholder advisory group • Plan to introduce state policy and regulatory changes (EMS) • Begin implementation of community paramedicine, urgent care expansion, mobile unit deployment and dialysis/ventilator purchase projects	• Convene regional transformation meetings at least quarterly in FFY 2026 and 2027 • Execute round one of provider grant awards by December 31, 2026, with quarterly reporting on outcomes • Initial regional and statewide hospital transformation plans completed by Jun 30, 2026 • Draft Statewide Health Care Strategic Delivery Plan completed by June 30, 2027 • Convene stakeholder advisory group at least quarterly
3: Midpoint	2028	• Data analyses and program evaluation of round 1 provider grants	• Interim Report on provider grants by December 31, 2027

Stage	Timeline (FFY)	Activities	Milestones
		• Select and award applicants for provider grants (round 2) • Leverage analytics support and technical assistance to develop and implement transformation plans • As needed, convene regional transformation meetings and workgroups to gather stakeholder input and align initiatives • Convene stakeholder advisory group	• Execute second round of provider grant awards by December 31, 2027, with quarterly reporting on outcomes • Finalize Health Care Strategic Delivery Plan by January 15, 2028 • Interim implementation reports from selected vendors for urgent care expansion, mobile unit deployment and dialysis/ventilator purchase projects by January 15, 2028. • Introduce and implement state policy and regulatory changes (EMS) by December 31, 2027 • Implement community paramedicine, urgent care expansion, mobile unit deployment and dialysis/ventilator purchase projects by September 1, 2028, with quarterly reporting on outcomes
4: Finalizing	2029	• Continued implementation of provider grants • Data analyses and program evaluation of round 1 and 2 provider grants • Leverage analytics support and technical assistance to develop and implement transformation plans • As needed, convene regional transformation	• Interim report on provider grants by December 31, 2028 • As needed, update Health Care Strategic Delivery Plan by January 15, 2029 • Interim reports from selected vendors for community paramedicine urgent care expansion, mobile unit deployment and dialysis/ventilator purchase projects by December 31, 2028

Stage	Timeline (FFY)	Activities	Milestones
		meetings and workgroups to gather stakeholder input and align initiatives • Refine and update the Health Care Strategic Delivery Plan	
5: Fully implemented	2030 (Some activities may continue into FY 2031, as needed)	• As needed, convene regional transformation meetings and workgroups to gather stakeholder input and align initiatives • Close out of provider grant programs • Final data analyses and program evaluation of provider grants • Develop sustainability plan and scaling recommendations • Prepare final reports for oversight and public dissemination	• Final outcome report for provider grants by September 30, 2030 • As needed, update Health Care Strategic Delivery Plan by January 15, 2030 • Final implementation reports from selected vendors for community paramedicine urgent care expansion, mobile unit deployment and dialysis/ventilator • Final outcome report for community paramedicine urgent care expansion, mobile unit deployment and dialysis/ventilator purchase projects by September 30, 2030

Initiative 2: Establishing a Clinically Integrated Network of Shared Services

Description	Vermont's independent hospitals and other providers deliver value to patients across the state but lack the scale and associated operational efficiencies that are characteristic of larger hospital networks. This initiative is designed to foster collaboration and partnerships across the continuum of independent providers in the state and implement a system of shared services to produce operational efficiencies. This "horizontal" collaboration will ensure choice and competition in the state's health care system, which will have downstream impacts on the affordability of care and patient access. Grant funding to providers will also enable purchase of necessary technologies to improve care delivery, to include telehealth, eConsult, RPM, and AI/scribe technologies. Vermont providers and clinical staff currently must access multiple systems in a patient's care, which creates inefficiencies, risks for poor

	outcomes, and turnover. All of these different systems limit the ability to collect patient care data and coordinate care across settings. AHS plans to collaborate with an organizing entity to implement key components of this initiative. This partnership of health care organizations will be established to enhance economic and financial stability, support clinical excellence, and adoption of leading-edge technologies.
Use of Funds and Estimated Cost	The state's use cases for RHT Program funds as part of this initiative include: • **Incentivizing adoption of a shared EMR platform:** Build upon Vermont's existing health data infrastructure, including VHIE, to strengthen data sharing and care coordination across the state. While the VHIE provides a robust platform for secure health data exchange, Vermont's hospitals and providers currently use a variety of EMR systems that cause administrative burden, increase complexity, and cause staff who work at multiple facilities to use different tools. This initiative would implement a shared EMR that complements and continues to contribute data to the VHIE. Participation would be voluntary and designed to achieve seamless data exchange, support improved image and lab sharing, enhance cybersecurity, and allow advanced data analytics. Leveraging the VHIE's existing infrastructure for state-wide sharing, while promoting a shared EMR, would reduce administrative burden, improve care coordination—particularly for rural populations—and advance statewide health system integration. • **Establishing a shared HRIS system:** Invest in the development of a unified HRIS that will centralize core human resources functions, including benefits administration, payroll, recruitment, onboarding, licensure tracking, and compliance, while allowing each participating hospital and community partners to securely manage organization-specific tasks such as performance evaluations and regulatory reporting. The system will streamline workforce management, reduce administrative costs, and support staff scheduling flexibility, allowing clinical teams to be shared or shifted to meet fluctuating patient volumes across regions. • **Statewide e-Consult expansion and workforce capacity building:** Support the implementation of a statewide e-Consult platform to ensure an interoperable means of access for primary care providers to consult with specialists. Grants will be provided to providers to enable purchase of technologies to support the build and function of an e-Consult platform. Funding will also be used for technology upgrades as well as startup program coordination costs that do not have an alternative funding source. Lastly, funding will be used to build capacity for pediatric and perinatal providers through a program that provides real-time psychiatric consultation, training, and resources, so

	they can confidently care for patients with mild to moderate MH needs in their primary care hub (Note: federal funding for this program concludes in SFY 2025–2026). Access to e-Consult services will save patients from having to travel to separate appointments and help strengthen local primary care capacity. • **Supporting a statewide closed-loop referral system:** Purchase a digital care coordination platform to strengthen communication and collaboration among health care, MH/SUD, and social service providers.[3] The system would ensure patients successfully connect to needed community supports, such as housing, food assistance, and transportation. By enabling real-time data sharing and tracking of referral outcomes, the platform would reduce duplication of services, improve accountability, and promote cost efficiency while ensuring more seamless, person-centered care across Vermont's health and social service systems. • **Creating a centralized tool to guide interfacility transfers:** Develop a shared subscription to a real-time digital tool that tracks bed capacity and service availability across Vermont's hospitals and health care facilities, modeled after Oregon's Capacity Center and Behavioral Health Coordination Center.[87,88] The system will enable more efficient and appropriate patient transfers by providing up-to-date visibility into available beds, specialty services, and transportation resources. Improved coordination would reduce ED boarding, prevent unnecessary transfers out of state, and ensure patients receive timely care at the most appropriate facility. • **Grants to providers to adopt RPM:** Provide grants to provider organizations for the purchase of RPM equipment. RPM would be used in home health, primary care/specialty, and community paramedicine settings. RPM enables earlier interventions and ongoing monitoring for chronic conditions (e.g., CHF, COPD, diabetes, hypertension, asthma for pediatric populations, etc.) in the home to prevent hospital admissions or readmissions. • **Grant funds to providers to adopt telehealth technology:** Provide grants to rural independent medical practices to purchase and implement telehealth technology solutions statewide. Funds would support investments in secure telehealth platforms, connected diagnostic tools, and related infrastructure necessary to deliver high-quality virtual visits (funds will not be used for broadband). Funds will be used to provide technical assistance and training to grantees on technology selection, implementation, cybersecurity, and compliance. By enabling smaller and independent practices to fully participate in

[3] A closed-loop referral system ensures that a member's needs are met by tracking a referral from the initial request to the confirmation of services received. This process involves coordinating with community-based organizations, confirming with the member they received the service, and providing feedback to the referring provider to close the communication cycle. This system is designed to improve care coordination, track outcomes, and efficiently connect members with resources for health-related social needs like housing or transportation.

	Vermont's evolving digital health ecosystem, this initiative will reduce barriers to access, improve continuity of care, and enhance the overall resilience of the state's rural health system. • **Grants to providers to adopt AI transcription/scribe technology:** Provide grants to providers to purchase AI scribe technology. Currently, smaller and more rural and independent practices are struggling with access to the same technology that larger practices can afford. AI scribe technology is proven to increase efficiency and reduce burden in primary care sites. Providers and patients in Vermont are expressing high satisfaction with scribe technology at those practices where it is already available. Scribes automate an average of over two hours of daily administrative work, transcribing and processing clinician-patient conversations, producing clinical notes and follow-up materials so clinicians can focus on delivering quality care to their patients. Investing in these services will produce clinical and administrative efficiencies for providers that will lead to improvements in the quality of care. **Estimated Budget Range**: $100–$200 million total across the five budget periods (not inclusive of state administrative costs). See the **Budget Narrative** for more information.
Relevant CMS Use of Funds Categories	A, C, D, F, G, H, K
Main CMS Strategic Goal(s)	Make Rural America Healthy Again, Sustainable Access, Tech Innovation
Relevant Technical Score Factors	B.1, C.1, E.2, F.1, F.2, F.3
Key Stakeholders	Hospitals, Health Systems, Community Providers Across the Health Care Continuum (Primary, Specialty, FQHCs, RHCs, etc.), Community-Based Organizations, Clinicians and Other Health Care Professionals, Patients.
Sub awardees/ Subcontractors	To be determined at a later date in accordance with state procurement rules.
Supporting Legislative and Regulatory Actions	None at this time.
Sustainability Plan	Vermont's investments in shared services are designed to produce lasting system efficiencies and operational improvements that extend well beyond the RHT funding period. The state will sustain these initiatives by

	embedding shared infrastructure within existing providers' governance and financing structures, leveraging state and provider partnerships to manage ongoing operations. Cost savings achieved through reduced administrative duplication, improved care coordination, and lower readmissions can be reinvested by providers into higher value activities. Once implemented, these shared systems will operate on subscription or cost-sharing models supported by participating providers leveraging dollars previously spent on duplicative administrative functions, allowing for continued maintenance, upgrades, and vendor support without reliance on federal funds. The state's robust Medicaid and private telehealth, RPM, e-Consult, and other virtual care coverage policies will be a key sustainability mechanism. The continuation of Medicare telehealth flexibilities will also contribute to sustainability for these services.
Impacted Counties	Statewide

Implementation Plan and Key Milestones for Initiative 2: Establishing a Clinically Integrated Network of Shared Services

Stage	Timeline (FFY)	Activities	Milestones
0: Planning	2026	• Conduct stakeholder engagement • Define governance for shared services • Assess readiness across providers • Identify key technology and workforce gaps • Develop data-sharing and privacy frameworks	• Governance structure approved by March 2026 • Baseline technical and workforce assessment completed by April 2026
1: Launch	2026	• Finalize project charters and funding priorities for each shared-service project (i.e., HRIS, EMR, interfacility transfer tool, closed-loop referral, e-Consult.) • Execute initial contracts • Launch statewide coordination meetings	• Project charters approved by June 2026 • Initial contracting started by July 2026

Stage	Timeline (FFY)	Activities	Milestones
2: Implementation	2027	• Deploy foundational infrastructure • Begin integration of shared HRIS and EMR systems • Implement early e-Consult and telehealth expansion pilots • Issue grants to providers for telehealth, RPM and AI	• Shared HRIS and EMR pilot sites operational by March 2027 • e-Consult live statewide by December 2027 • Interfacility transfer tool and closed-loop referral platform live statewide by December 2027 • All provider grants issued by December 2027
3: Midpoint	2028	• Conduct midpoint evaluation • Expand provider participation • Refine operational policies based on data and stakeholder feedback	• Midpoint evaluation completed by June 2028
4: Finalizing	2030	• Refine statewide rollout of all shared service tools • Formalize sustainability and governance models • Document quality, efficiency, and cost outcomes	• All shared systems live statewide by September 2030
5: Fully implemented	2030	• Maintain full network operation across all domains • Integrate continuous quality improvement • Report on system-wide outcomes • Ensure long-term funding and oversight alignment	• Comprehensive outcome report delivered by September 2030

***Initiative 3**: Strengthening Primary Care*

Description	The Vermont Blueprint for Health is an existing initiative in the state that designs community-led strategies for improving health and well-being. RHT Program funds will create a modern, enhanced iteration of the

	Blueprint model.[4] There are no existing funding sources for updating the Blueprint's current model, which originated in 2005 and is now outdated. The new initiative will focus on four core areas: 1. *Integrated and Coordinated Treatment for Complex Chronic Conditions*: Vermont's primary care-based community health teams are under-resourced and insufficiently integrated with specialty care. Modern teams, supported by a new payment model, will include a broad range of professionals. These teams will address the root causes of diseases and provide coordination for patients with complex chronic conditions or risk factors for complex conditions. A special focus will be on establishing a prescribed mix of professionals able to help patients with conditions such as diabetes, MH/SUD, COPD, CHF, and hypertension as well as social service needs, such as recovery housing. Vermont will establish new standards for services to be implemented within practices to improve team-based chronic disease care. For example, standardized screening and risk-stratification will allow care to be tailored to the needs of the patients. Community health team staff will bridge primary and specialty care, ensuring each patient receives consistent, person-centered support aligned with their individual goals and community resources. 2. *Evidence-Based Practice and Workforce Training*: To standardize care and ensure consistency across the state, providers will adopt clear, Vermont-specific guidelines aligned with national best practices and guidelines promoted by the U.S. Department of Health and Human Services. Training and competency-building for the treatment team will promote evidence-based care, while enhanced patient education will strengthen self-management skills and confidence. Centralized resources and shared learning will ensure community health teams use the most current, effective interventions to achieve measurable outcome goals. 3. *Transformation Assistance for Primary Care Practices*: Many primary care practices need analytic and technical support to identify and manage high risk populations. The new Blueprint model will offer transformation assistance to integrate data-driven care coordination and close gaps across disciplines. 4. *Continuous Quality Improvement and Learning*: The new model will create a statewide learning network to support ongoing performance monitoring, shared of best practices, and continuous refinement of care models. Using real-time data and defined outcome measures, teams conduct continued quality improvement to improve patient health, provider satisfaction, and system efficiency.

[4] The state can produce a list of primary care practices, including those affiliated with Blueprint for Health, upon request.

Use of Funds and Estimated Cost	The state's use cases for RHT Program funds as part of this initiative include: • **Providing enhanced capacity for team-based care:** Fund payments to improve team-based care implementation to support care coordination and prevention-focused interventions such as chronic disease management, nutrition, and exercise programs. This payment will be a prospective PMPM amount to support community health team staff, who do not bill their activities. Practices will receive payment based on agreeing to implement new standards and their performance on these standards. The PMPM will help increase access to services, including provision of care, and evidence-based chronic disease prevention and management for all Vermonters. • **Incentivizing access to primary care:** As part of the modernized Blueprint model, primary care practices that meet access requirements will receive a PMPM capacity payment, supported by RHT Program funds. Enhanced access requirements will improve patients' ability to receive the care they need when and where they need it. Examples of the types of requirements needed to earn the capacity payments include waitlist reduction for new patients, ensuring availability of after-hours and/or weekend appointments, RPM, mobile health or home-visiting, telehealth, and same-day appointments for existing patients. • **Specialty and primary care performance payments:** Funds will provide performance payments, as PMPM payments, that will be shared between specialty and primary care providers to incentivize consultation, co-management, and coordination of care for the following conditions: diabetes, MH/SUD, COPD, CHF and hypertension (additional conditions may be added in future years). These payments are intended to incent providers to work together differently, facilitated by technology (e.g., e-Consults, telehealth). These payments will depend on the shared performance of providers. • **MH and community support integration into primary care teams:** Funds expanded staffing recruitment efforts at primary care practices to provide comprehensive, team-based care for activities that have no reimbursement model. Embedding MH and community support specialists within existing clinical teams will strengthen coordination between physical, MH, and social services. This allows patients to access timely, whole-person support in a familiar setting. The model will enhance screening, early intervention, and care planning for patients with intertwining needs, reduce barriers to care access, and improve outcomes through closer collaboration between clinicians, care coordinators, and community-based partners, including transportation partners. • **Enhancing Blueprint transformation network capacity:** Invest in the Blueprint's statewide network of practices to allow for the

	modernization of the model. The project will support technical assistance, training, and practice transformation resources that help providers implement new care standards and evidence-based approaches. Priority areas include chronic disease prevention and management, integration of MH/SUD and physical health, and improved use of data to drive quality and outcomes. • **Workforce support and system integration development:** Support efforts to strengthen the health workforce and provide tools used for patient/family engagement, referral/consultation workflows and systems, and bilateral communication mechanisms. Funds will also serve to implement evidence-based chronic disease prevention and management, training and technical assistance, and training for the clinical workforce. • **Enhancing primary care-focused data and analytics infrastructure:** Provide funding to expand statewide access to eCQM calculation tools, risk stratification modules, referral tracking, and team-based care documentation. This will strengthen data-driven care coordination and performance improvement. Investments will support practices in leveraging these tools to identify high-risk populations, monitor outcomes, and streamline reporting. Further, investments will enable primary care practices to harness data and technology to furnish high-quality health care services. • **Expanding access to FQHC primary care services:** Provide funding to an FQHC to adapt existing clinical sites through minor infrastructure renovations/refurbishments and equipment upgrades to expand access to care (in alignment with HRSA's approved scope). Funds will also be used to pay for resources related to formal onboarding and training of staff and investments in IT. In addition, funding will support costs related to health data information transfer and community engagement and public relations activities. • **Expanding access to recovery housing for individuals with SUD needs:** Provide grants for the minor renovation and refurbishment of existing housing to increase capacity to support individuals in recovery. Through this investment, the state will ensure that individuals provided primary care through the Blueprint for Health's community health teams will be able to access recovery housing. Recovery housing's evidence-based model will provide a stable environment for individuals with SUD and co-occurring conditions to focus on recovery through encouraging peer support, personal growth, and long-term recovery skills. **Estimated Budget Range**: $200–$300 million total across the five budget periods (not inclusive of state administrative costs). See the **Budget Narrative** for more information.

Relevant CMS Use of Funds Categories	A, B, C, D, E, F, H, I, J, K
Main CMS Strategic Goal(s)	Make Rural America Healthy Again, Sustainable Access, Workforce Development, Innovative Care, Tech Innovation
Relevant Technical Score Factors	B.1, B.2, C.1, D.1, E.1, E.2, F.1, F.2, F.3
Key Stakeholders	AHS Interdepartmental Partners, Payers, Provider Networks, FQHCs/RHCs, Primary Care and Specialty Care Clinics, Community-Based Organizations, Blueprint Executive Committee, Blueprint Payment Implementation Workgroup, Vermont Steering Committee for Comprehensive Primary Health Care, Health Care Delivery Advisory Council, Health Care Reform Oversight Committee, Patients
Sub awardees/ Subcontractors	To be determined at a later date in accordance with state procurement rules.
Supporting Legislative and Regulatory Actions	None at this time.
Sustainability Plan	Vermont's strengthening primary care initiative is designed to create lasting improvements in access, coordination, and quality that extend beyond the RHT funding period. The state will sustain these investments by leveraging and expanding existing reimbursement models (Medicaid, Medicare, private) for primary care service delivery. Engagement with CMS's AHEAD Model will enable Vermont to test and scale sustainable payment approaches for advanced primary care, care management, and community health team services that were started using RHT funding. Specifically, AHEAD will sustain investments in targeted care management across the state's rural primary care practices. The state will also engage commercial payers in the modernization of the model to ensure the investment is sustained by all payers. RHT-funded data and analytics infrastructure, referral systems, and evaluation capacity improvements will be institutionalized within the Blueprint model, replacing existing infrastructure. These improvements will be maintained through the shared State and payer contributions and operational efficiencies and savings created by high quality, coordinated care. The Blueprint's existing governance and accountability structures will support ongoing use of this model to improve population health, care quality, and system sustainability beyond FY 2031.

Impacted Counties	Statewide

Implementation Plan and Key Milestones for Initiative 3: Strengthening Primary Care

Stage	Timeline (FFY)	Activities	Milestones
0: Planning	2026	• Project planning • Advisory group identification • Scoping process • Staff need determinations • (FQHC project only): Add service area to scope, lease properties, hire or contract for staffing, renovate sites and perform data integration	• Advisory groups determined by March 2026 • Project plan finalized by March 2026
1: Launch	2026	• Hire project staff • Conduct contracting process • Advisory group engagement sessions • Standard development and deployment • Baseline data collection • (FQHC project only): Conduct training, data collection, and analysis	• Advisory groups convened by May 30, 2026 • Standards determined by June 30, 2026 • Community health team staff hiring begins by July 1, 2026 • Contracts executed by September 30, 2026 • Baseline data collected by September 30, 2026
2: Implementation	2027	• Community Health Teams hire staff and reorganize to meet new standards • Conduct training for staff and technical assistance for practices • Begin complex care management • Implement statewide referral system • Begin telehealth and EMR improvements • Begin recovery housing refurbishments	• Statewide referral system implemented by January 1, 2027 • Practices attest to new standards by September 30, 2027 • Recovery housing refurbishments completed by September 30, 2027 • (FQHC project only): Expanded sites operational by September 30, 2027

Stage	Timeline (FFY)	Activities	Milestones
		• Introduce policy or regulatory changes as needed	• Policy/regulatory changes introduced by December 31, 2027
3: Midpoint	2028	• Midpoint evaluation • Program expansion to increase service provision • Update plan based on evaluation	• Project plan updates by June 30, 2028 • Midpoint evaluation completed by September 30, 2028 • (FQHC project only): Submit interim report by September 30, 2028
4: Finalizing	2029	• Quantitative final evaluation • Develop sustainability plan	• Claims-based evaluation by September 30, 2029 • Sustainability plan by September 30, 2029
5: Fully implemented	2030	• Full operation with measurable outcomes • Ongoing evaluation, measurement, and quality improvement	• Full operation outcome report by September 30, 2030 • (FQHC project only): Submit final report by September 30, 2028

***Initiative 4**: Health Care Workforce Development*

Description	This initiative is designed to strengthen the state's rural health care workforce pipeline and enable providers in the state to operate at the top of their license through strategic investments in recruitment, training, and retention. Vermont's health care workforce faces persistent challenges stemming from aging demographics and limited educational pathways in rural regions. Further, there is a shortage of housing stock for health care workers. Increased interstate competition and resulting turnover are significantly impacting workforce costs and/or creating significant gaps in care. While many organizations have independently developed successful health care workforce programs to address some of these challenges, efforts remain fragmented and vary in scale. RHT Program funds present an opportunity to align and expand these programs. The goal of this initiative is to foster collaboration and partnerships among hospitals, educational institutions, and community partners to develop coordinated, regionally focused recruitment and training approaches that build a sustainable health workforce for the future. This application's workforce development plan dovetails with the initiatives described above, by

	ensuring a dedicated and highly trained workforce will be available to drive these complementary efforts. The state will ensure that health care professionals participating in the projects below, where relevant, commit to practice in-state for at least five years (or longer), with clear protections to ensure that no provider is bound by non-compete agreements. Sub-recipients are responsible for implementing a comprehensive five-year service agreement process, and AHS will provide oversight. Sub-recipients must draft service agreements that outline the five-year commitment, specify program/recipient obligations, and define consequences for breaches, while allowing for exceptions in unforeseen circumstances. AHS will conduct annual reviews to ensure adherence, and sub-grantees must report annually on the status of individuals provided assistance through the training and financial assistance/housing programs below.
Use of Funds and Estimated Cost	The state's use cases for RHT Program funds as part of this initiative include: *Training Programs* • **Expand access to LNA training programs:** Invest in new LNA training opportunities across Vermont through hybrid education models and coordinated clinical partnerships. Today, Vermont offers several accessible, work-based training options for LNA candidates, allowing them to gain paid experience while completing required coursework. However, these programs are fragmented. RHT Program funds would support creation of a new centralized training hub and shared clinical placement opportunities for small and rural providers that lack the capacity to host their own programs. This project will help strengthen Vermont's long-term care and hospital workforce pipeline while supporting career advancement within the nursing profession. • **Establish the Maple Mountain Consortium Family Medicine Residency program:** Invest in startup and the first four years of operations for Vermont's first rural teaching health center family medicine residency programs. [The state will be contributing from its own funds to support startup in collaboration with but not supplanted by RHT's funds.] This accredited residency program is ready to launch and would strengthen the state's primary care workforce by training physicians in rural and community-based settings where they are most needed. RHT funds may also support the program's efforts to expand training for additional health professionals (e.g., dental residents and APRNs). Upon full implementation, the program will produce at least 12 family medicine physician graduates annually. • **Health care professions residency program:** Provide grant funding to support the ability of providers, such as rural home health agencies, rural hospitals, and other health care organizations, to identify preceptors, recruit residents, conduct training and education, and

incentivize program participants to remain employed at the provider organization. Funds will enable statewide promotion of the program to educational institutions and prospective residents, provide recruitment materials, coordinate peer learning and support groups among residents, create preceptor support structures, provide curriculum support and materials, and assist with program reporting to state.

Financial Assistance and Housing

- **Health care workforce development tuition assistance program:** Funds would extend new coverage of licensing renewal fees, exam costs, continuing education unit training, and stipends to pay interns for community-based providers, including but not limited to MH, SUD, and intellectual and developmental disability providers. This project is crucial toward promoting access to essential community services.
- **Health care "critical occupations" no-cost tuition program:** Fund new activities to expand a "critical occupations" no-cost tuition program to enable access to education and training for high-demand health professions, including registered nursing, radiologic science, respiratory therapy, dental hygiene, and others. The program will provide last-dollar tuition support, covering any remaining tuition and fees after institutional, state, and federal gift aid is applied. Combined aid would not exceed a student's total cost of attendance, ensuring responsible use of funds.
- **Health care workforce conditional financial assistance program:** Invest in attracting and retaining qualifying students (e.g., nurses, radiology technicians, medical technicians) through the provision of financial assistance. The program will reduce financial barriers to entering and remaining in provider organizations within the state. Scholarships are granted once participants sign a promissory note and fulfill their required in-state service obligation.
- **Health care workforce housing program:** Fund a new workforce housing program to increase the amount of housing stock available to health care workers in rural parts of the state. This program would provide grants of up to $50,000 per unit to property owners for minor renovations and refurbishments needed to bring vacant rental units up to Vermont Rental Housing Health Code guidelines, add new units to an existing building within the current building footprint, or convert commercial or retail space into housing. Property owners are required to provide a 20% match for project grants and maintain the Department of Housing and Urban Development Fair Market Rent prices. More specifically, funds will (1) rehabilitate existing vacant units; (2) rehabilitate structural elements affecting multiple units, such as the lighting/electrical/plumbing/HVAC systems of a multi-family property, interior modifications, and accessibility improvements; and (3) create new units within an existing structure or convert commercial or retail space to residential. Health care organizations may apply to AHS to

	receive an allocation. The health care organizations will partner with one of the five Vermont Homeownership Centers based on their region, which will be the fiscal agent and administrator of the agreements. Property owners will submit an application to their regional Center. Recipients of the grants must agree to only allow qualifying health care providers to occupy the unit. *Scope of Practice* • **Expand pharmacists' scope to include test-to-treat in more scenarios (i.e., COVID-19, flu, strep throat):** Fund a pilot program to broaden access to timely diagnosis and treatment through enhanced utilization of pharmacists operating at the top of their license. RHT funds would support the development of training modules, the establishment of necessary infrastructure (including technology and equipment), and pilot reimbursement mechanisms for expanded pharmacy-based services. By leveraging pharmacists as accessible, community-based providers, this initiative will enhance primary care capacity, reduce unnecessary emergency visits, and strengthen Vermont's integrated rural care delivery system. **Estimated Budget Range**: $100–$200 million total across the five budget periods (not inclusive of state administrative costs). See the **Budget Narrative** for more information.
Relevant CMS Use of Funds Categories	D, E, H, J, K
Main CMS Strategic Goal(s)	Workforce Development, Innovative Care
Relevant Technical Score Factors	C.1, D.1, D.3
Key Stakeholders	Educational/Workforce Institutions, Providers, Hospitals, Vermont Housing Improvement Program, Vermont Housing Finance Agency, Housing Developers, Vermont Homeownership Centers, Agency of Commerce and Community Development, Clinicians and Other Health Care Professionals
Sub awardees/ Subcontractors	Maple Mountain Residency Program; other recipients to be determined at a later date in accordance with state procurement rules.
Supporting Legislative and Regulatory Actions	Changes are required to current statute to support and accommodate broad expansion of test-to-treat in pharmacies. For example, 26 Vermont Statutes Annotated § 2023(b)(2)(A) currently authorizes the creation of two pharmacist prescribing protocols related to administering COVID-19

	testing only. Neither protocol was developed, to date, because pharmacists are still authorized to test-and-treat for COVID under the amendments to the declaration of the Public Readiness and Emergency Preparedness Act, which has been extended until the end of 2029. Vermont will pursue state policy and regulatory changes to enable expansion of pharmacists' scope of practice to allow for test-to-treat for additional situations. As mentioned in other areas of this application, Vermont is also expanding the scope of EMS (see **Initiative 1**) and CRNA providers (see **Legislative and Regulatory Action** section).
Sustainability Plan	The sustainability of Vermont's projects within this initiative will be strengthened by the state's ongoing strategic planning for health care workforce development, conducted in collaboration with stakeholders and community members. The state is committed to establishing self-sustaining partnerships and models to ensure the longevity and evolution of rural workforce programs. The proposed training, residency, and recruitment and retention initiative models can be easily adapted and implemented across various settings, ensuring consistent and widespread impact. These investments, along with five-year commitments to remain in the state, will strengthen the state's pipeline for a time long after funds from the RHT Program expire. The scope of practice policy initiatives also have the potential for replication in other areas as the state identifies and refines the processes involved. By developing clear guidelines and best practices, these initiatives can be adapted to different health care settings, allowing for broader implementation and impact. The housing project leverages lessons learned in the state for similar efforts, which will enhance its sustainability by building on proven frameworks and resources. By pursuing diversified funding sources, such as increased state appropriations and public-private partnerships with health care providers and employers, we aim to co-fund initiatives that will remain viable beyond the RHT funding period. This approach leverages a mix of state appropriations, private sector contributions, and community support to maintain and evolve these programs over time, reducing the risk of relying on a single funding source. Vermont's projects within this initiative can easily be ramped up or down pending availability of funds, which the state has done in the past. RHT Program funds are a critical resource for the state that will have lasting impacts even if sustainability is not assured in future years.
Impacted Counties	Statewide

Implementation Plan and Key Milestones for Initiative 4: Health Care Workforce Development

Stage	Timeline (FFY)	Activities	Milestones
0: Planning	2026	• Conduct project planning • Identify work teams • Develop the scope for all health care workforce development programs • Determine staffing needs	• Work teams identified by January 30, 2026 • Health Care Workforce Advisory group informed by March 2026 • Project plan finalized by March 2026
1: Launch	2026	• Hire project staff • Conduct staff training • Engage work teams • Conduct contracting process • Develop and deploy contract and sub awards (launch date for projects above may vary) • Hold information sessions • Collect baseline data • Plan for state policy and regulatory changes related to pharmacist test-to-treat project	• All work teams convened by April 30, 2026 • Staff onboarding completed by May 30, 2026 • Contract and sub award standards determined by June 30, 2026 • Information sessions held by July 30, 2026 • Contracts and sub awards executed by September 30, 2026 • Baseline data collected by September 30, 2026
2: Implementation	2027	• Monitor contracts and manage applications, and compliance • Implement policy or regulatory changes • Provide support and oversee grants, training partnerships, and reporting • Coordinate payments with agencies and track outcomes • Conduct annual evaluations	• Annual reports due by September 30, 2027 • Introduce and implement state policy and regulatory changes by September December 31, 2027
3: Midpoint	2028	• Conduct midpoint evaluations and analytics • Identify and implement necessary changes to	• Midpoint evaluation completed by Sept 30, 2028

Stage	Timeline (FFY)	Activities	Milestones
		health care workforce development programs, as needed • Update project plan based on evaluation	• Project plan updates by November 30, 2028
4: Finalizing	2029	• Conduct annual evaluations • Develop a sustainability plan	• Annual evaluations by September 30, 2029 • Sustainability plan by November 30, 2029
5: Fully implemented	2030	• Conduct final evaluations • Achieve full operation • Continue ongoing evaluation, measurement, and quality improvement for each health care workforce development program	• Final evaluations by September 30, 2029 • Full operation outcome report by November 30, 2030

***Initiative 5**: Price Transparency and Insurance Competition*

Description	This initiative aims to increase access to affordable, high-quality care for rural Vermonters by improving transparency, strengthening insurance market participation, and expanding affordable coverage options. As noted above, Vermont's rural communities continue to face rising health care costs, limited plan choices, and barriers to understanding and comparing health care prices and quality. RHT Program funds will support two complementary projects: • The first will enhance the state's ability to produce timely, accurate, and comprehensive analysis of cost, quality, and access metrics through a technical platform. This investment will allow policymakers, regulators, and the public to evaluate health system performance, identify improvement opportunities, and track progress toward statewide health reform goals. • The second will support a statewide assessment to evaluate options to enhance health care coverage affordability for Vermonters. Findings from this assessment will inform state decision-making, guiding near- and long-term policy actions to improve sustainability of the state's Marketplace, called Vermont Health Connect, and explore new affordability strategies (e.g., reinsurance, Basic Health Plan).
Use of Funds and Estimated Cost	The state's use cases for RHT Program funds as part of this initiative include:

	• **Statewide health care data platform modernization and transparency project:** This project aims to modernize how cost, quality and access data is managed and used in Vermont by scaling existing infrastructure. RHT funds will support development of a scaled solution that will replace older tools and make it easier for state leaders, health care providers, and the public to see how well the health care system is working according to defined metrics. Additionally, the solution will use dashboards and reports to show important facts and trends, like how much health care costs are rising, the quality of care provided, and access to care. By using modern technology, the project will help people make smarter decisions about health care and track progress toward improving health services across the state. • **Statewide assessment of options to improve health coverage affordability:** Invest in a statewide assessment and associated technical assistance to identify and advance policy options to improve access and affordability in Vermont's Marketplace. The assessment will explore options to promote marketplace sustainability for insurers and consumers, including small businesses. The assessment will identify what the state can do now, what requires near-term analysis, and what could be implemented in 2028. Funds will provide technical support to analyze reinsurance and Basic Health Program affordability options, prepare federal waiver applications, and support marketplace plan design innovation. DVHA/AHS will undertake a Request for Information or other pre-procurement vehicle(s) to collect information from the national issuer community on perceived barriers to entering the Vermont market. **Estimated Budget Range**: $10–$50 million total across the five budget periods (not inclusive of state administrative costs). See the **Budget Narrative** for more information.
Relevant CMS Use of Funds Categories	D, F, G
Main CMS Strategic Goal(s)	Sustainable Access, Tech Innovation
Relevant Technical Score Factors	F.2
Key Stakeholders	DVHA, DFR, Insurance Carriers, Consumers
Sub awardees/ Subcontractors	To be determined at a later date in accordance with state procurement rules.

Supporting Legislative and Regulatory Actions	Vermont will pursue the Marketplace request for information and plan design work without legislation; however, some policies will have legislative and budget implications for SFY 2028 that the state will make available to CMS.
Sustainability Plan	Vermont will sustain the statewide health care data platform modernization and transparency initiative beyond FY 2031 using state funding. RHT Program funding represents a one-time investment to make upgrades to the state's platform. During the project, experts will train state employees and provide guides and documentation to build internal knowledge to sustain the initiative beyond the RHT Program. Vermont plans to use non-RHT dollars to fund the implementation of any options identified through the statewide assessment of options to improve health coverage affordability. Following the completion of the assessment, Vermont will pursue a combination of state and federal funding to implement identified policy actions. For example, Vermont may seek federal approval from CMS to implement a reinsurance program or establish a basic health program in the state. Vermont intends to take identified policy actions by January 2028 to align with other changes made to the Marketplace under the H.R.1 - One Big Beautiful Bill Act of 2025.
Impacted Counties	Statewide

Implementation Plan and Key Milestones for Initiative 5: Price Transparency and Insurance Competition

Stage	Timeline (FFY)	Activities	Milestones
0: Planning	2026	• Form teams to guide both projects; hire external contractors or partner resources to design and execute data builds for the transparency project • Identify data sources for the transparency project to include, success metrics, and key performance indicators for cost, quality, and access • Develop initial governance, staffing, and contracting plans	• Governance groups formed and plans approved by March 2026 • Scopes of work finalized by June 2026 • Vendor and staffing plans completed by September 2026

Stage	Timeline (FFY)	Activities	Milestones
1: Launch	2026	• Begin transparency project platform design and contracting; and develop baseline data models and dashboards • Begin analysis for marketplace insurance and reinsurance	• Technical contracts executed by September 2026 • Baseline cost, access, and quality requirements defined for the transparency project by December 2026
2: Implementation	2027	• Operationalize the unified data environment for the transparency project to enable timely, accurate, and comprehensive analysis of health system performance • Complete analysis of marketplace insurance and reinsurance	• Operationalize the new data environment by March 2027 • Complete analysis of marketplace insurance and reinsurance by December 2027
3: Midpoint	2028	• Evaluate progress for both projects	• Midpoint evaluation complete by June 2028
4: Finalizing	2030	• Develop a final report for both projects, including sustainability assessment	• Final report complete by December 2029
5: Fully implemented	2030	• Maintain regular updates for both projects • Continue stakeholder input and quality improvement	• Deliver annual report by September 2030

Metrics and Evaluation Plan

Below are the performance metrics and outcomes Vermont will track to evaluate success for each initiative, as well as Vermont's plans for evaluating the program. The data and targets in the table are for the whole state, but Vermont will also look for ways to break down the information by rural areas and different groups of people. As noted in the table, many of the proposed metrics can be reported at the HSA level, which is similar in location and size to counties and reflective of where people receive their care. Vermont has selected these metrics based on feasibility of

measurement and collection of required data and relevance to the state's RHT Program objectives and initiatives.

Metric	Data Source	Timing of Data Updates	State or Provider Data Collection	Baseline Data	Targets
Initiative 1. Regionalization and Innovative Care Strategies: *Projects within this scope are intended to reduce the need for acute care and right-size care delivery across the state.*					
Follow-Up After ED Visits for Mental Illness, ages 6 and older: 30-Day Rate (HEDIS FUM)	Claims from APCD	Annual; 1–2 CY lag for claims data to be compiled	State; can be reported by HSA	Statewide baseline was 76.3% in 2023	Greater than or equal to 78% by the end of budget period 5
Follow-Up After ED Visits for Substance Use, ages 13 and older: 30-Day Rate (HEDIS FUA)	Claims from APCD	Annual; 1–2 CY lag for claims data to be compiled	State; can be reported by HSA	Statewide baseline was 67.7% in 2023	Greater than or equal to 69% by the end of budget period 5
Plan All-Cause Readmissions, ages 18 and older (HEDIS PCR)	Claims from APCD	Annual; 1–2 CY lag for claims data to be compiled	State; can be reported by HSA; potential small numbers for some HSAs	Pending all-payer calculation	Pending all-payer baseline data
Number of hospitals with completed transformation plans (Vermont-specific metric)	Project report (state determines completion)	Annual	State; can be reported by hospital type and location	Zero; transformation plans to be developed	All hospitals by budget period 5
CAH operating margins (Vermont-specific metric)	Hospital year-end budget submissions to State (GMCB)	Annual, for prior HFY	Providers submit data; state analyzes, aggregates, and reports; can be reported by hospital and HSA	50% of CAHs had positive operating margins in HFY 2024. Margin was negative 1.2% when aggregating all CAHs	Target to be determined after further analysis

Metric	Data Source	Timing of Data Updates	State or Provider Data Collection	Baseline Data	Targets
Number of Community Paramedicine Visits and/or Patients (Vermont-specific metric)	Project report; may eventually be able to obtain via claims from APCD	Quarterly	Provider submission to state; state will aggregate	For the two-year period 10/1/2023 through 9/30/2025: 353 referrals, 309 active patients and 1737 visits	600 patients served and 3,400 visits by the end of budget period 5
Initiative 2. Establishing a Clinically Integrated Network of Shared Services: *Projects within this scope are intended to increase adoption of technologies to enable operational efficiencies for independent providers and facilitate delivery of comprehensive care closer to home.*					
Number of rural independent practices obtaining telehealth equipment (Vermont-specific metric)	Project report	Quarterly	State; can be reported by HSA	Zero; program to be developed	Target to be determined
Numbers of providers and/or patients using RPM (Vermont-specific metric)	Project report	Quarterly	State; can be reported by HSA	Unknown; program to be developed	Target to be determined
Implementation of statewide closed-loop referral system; number of providers (Vermont-specific metric)	Project report	Quarterly	State; can be reported by HSA	Zero; program to be developed	Target to be determined
Prevention Quality Indicator Chronic Conditions Composite (Agency for Healthcare Research and Quality	Hospital Discharge Database	Annual; 1–2-year lag	State; can be reported by HSA; potential small numbers for some rural HSAs	Statewide baseline was 559.83 per 100,000 population in 2022 (lower is better)	550 per 100,000 population average by the end of budget period 5

Metric	Data Source	Timing of Data Updates	State or Provider Data Collection	Baseline Data	Targets
Prevention Quality Indicator 92)					
Initiative 3. Strengthening Primary Care: *Projects within this scope are intended to improve primary care outcomes and engagement in primary care services.*					
Glycemic Status Assessment for Patients with Diabetes, ages 18-75: Glycemic Status >9.0% (HEDIS GSD)	Claims from APCD; Clinical Data from Health Information Exchange	Annual; one CY lag for claims data to be compiled	State; can be reported by HSA	Statewide baseline was 21.8% in 2023 (lower rate is better)	Less than or equal to 21% by the end of budget period 5
Controlling High Blood Pressure for People with Hypertension, ages 18-85 (HEDIS CBP)	Claims from APCD; Clinical Data from Health Information Exchange	Annual; one CY lag for claims data to be compiled	State; can be reported by HSA	Statewide baseline was 75.8% in 2023	Greater than or equal to 78% by the end of budget period 5
Screening for Depression and Follow-up Plan, ages 12 and older (CMS eCQM 2)	Provider reports submitted to state portal	Annual	Providers report measure results to state portal; state aggregates; can be reported by HSA	Statewide baseline (weighted average) was 63.2% in 2024 for practices participating in Blueprint Model	Greater than or equal to 66% by the end of budget period 5
Patients with Community Health Team engagement (Vermont-specific metric)	Provider reports submitted to state portal	Quarterly (annual reporting is average per quarter)	Providers report results to state portal; state aggregates; can report by HSA	Average of 26,800 patients per quarter in 2024	Greater than or equal to 27,000 patients per quarter in budget period 5
Child and Adolescent Well-Care Visits, ages 3-21 (HEDIS WCV)	Claims from APCD	Annual; one CY lag for claims data to be compiled	State; can be reported by HSA	Statewide baseline was 59.4% in 2023	Greater than or equal to 61% by the end of budget period 5

Metric	Data Source	Timing of Data Updates	State or Provider Data Collection	Baseline Data	Targets
Adults' Access to Preventive/ Ambulatory Health Services, ages 20 and older (HEDIS AAP)	Claims from APCD or Global Commitment Scorecard (Medicaid only)	Annual; one CY lag for claims data to be compiled	State; can be reported by HSA	Statewide Medicaid baseline was 76.7% in 2024	Target to be determined after obtaining baseline all-payer data
Initiative 4. Health Care Workforce Development: *Projects within this scope are intended to increase the state's workforce and address provider shortages, improving accessibility to care and downstream population health outcomes.*					
Number of FTEs practicing in various disciplines showing stable or upward trends (Vermont-specific metric)	Vermont Department of Health Census of Selected Health Care Providers	Every two years, during provider re-licensure	State conducts provider survey during re-licensure and performs analysis; can report by County	The following providers have been showing stable or upward trends in FTE counts in recent years: MH Counselors: 658.6 (2023) APRNs-Primary Care: 323.5 (2023) Pharmacists: 489.3 (2023) Social Workers: 860.8 (2024)	Aging workforce is a significant concern in Vermont. The goal is to maintain growth in provider types that are stable or increasing. Target for provider types that are increasing: Increase FTEs by at least 2% by the end of budget period 5.
Number of FTEs practicing in various disciplines showing decreases in FTE counts in recent years or at risk	Vermont Department of Health Census of Selected Health Care Providers	Every two years, during provider re-licensure	State conducts provider survey during re-licensure and performs analysis; can	The following providers have been showing decreases in FTE counts in recent years or are at risk of decreasing:	The goal is to stabilize provider types that are declining.

Metric	Data Source	Timing of Data Updates	State or Provider Data Collection	Baseline Data	Targets
of decreasing due to aging workforce or other factors (Vermont-specific metric)			report by County	LNAs: 2204.4 (2022) RNs: 4203.3 (2023) Physicians-Primary Care: 406.3 (2022) PAs-Primary Care: 76.4 (2024)	Target for provider types that are decreasing: Reduce downward trend in FTEs by at least 2% by the end of budget period 5.
Number of pharmacists engaging in expanded test-to-treat (Vermont-specific metric)	Project reporting and/or claims	Annual	Likely to be state; could report by County or HSA	Zero; program to be developed	Target to be determined
Number of people supported by workforce training and financial assistance programs (Vermont-specific metric)	Project reporting	Annual	Providers or project leads will submit data; state will aggregate; could report by County or HSA	Zero residents in Maple Mountain Consortium (2025); 276 people in other programs	300 people in workforce training and financial assistance programs by the end of budget period 5
DA/SSA Overall Vacancy Rate (Vermont-specific metric)	Department of Mental Health DA/SSA Workforce Recruitment and Retention Strategic Plan	Monthly	Providers submit data to state; state aggregates, analyzes, and reports	Statewide baseline rate was 14% on July 1, 2025 (lower is better)	Less than or equal to 12.5% by budget period 5
Initiative 5. Price Transparency and Insurance Competition: *Projects within this scope are intended to improve care affordability, transparency, and reverse health care cost trends.*					

Metric	Data Source	Timing of Data Updates	State or Provider Data Collection	Baseline Data	Targets
Growth in hospital operating expenses, including CAHs (Vermont-specific metric)	Hospital year-end budget submissions to State (GMCB)	Annual, for prior HFY	Providers submit data; state analyzes, aggregates, and reports; can be reported by HSA	Rate of growth from HFY 2023 to HFY 2024 was 8.9%	Targets to be determined pending further analysis
Growth in total cost of care (Vermont-specific metric)	Claims from APCD and non-claims data	Annual; 1–2 CY lag for claims data to be compiled	State; can be reported by HSA	Rate of growth for all-payer total cost of care was 10.3% from CY 2022 to CY 2023	Targets to be determined pending further analysis
Vermont Health Connect insurer and plan options (Vermont-specific metric)	Insurers submit filings to state	Annual, for subsequent CY	State, based on insurer filings	In 2025-2026, there are two insurers offering standard (required) and nonstandard qualified health plans to individuals and small businesses	Maintain at least two insurers by the end of budget period 5; create at least one new plan design in response to market demand by the end of budget period 5
Marketplace sustainability and affordability options (Vermont-specific metric)	Project report; likely qualitative information	Annual	State	Documented issues regarding health and affordability of marketplace	Produce a report summarizing options by the end of budget period 5
Unique users of new health care cost, quality, and access tools	Various data sources; new data build	Annual	State	Not available; systems do not exist currently	Augment systems by the end of budget

Metric	Data Source	Timing of Data Updates	State or Provider Data Collection	Baseline Data	Targets
(Vermont-specific metric)					period 5; target to be determined

Vermont will select an external evaluator through a competitive procurement that will be initiated during the first budget period. The selected vendor will be responsible for overall assessment and evaluation of the program, including:

- Understanding the context of Vermont's RHT program;
- Developing a deep knowledge of the activities undertaken as part of each initiative described above;
- Designing the evaluation;
- Using existing data sources and collecting additional data and information, as needed;
- Analyzing the data and information; and
- Presenting results, conclusions, and recommendations.

Vermont will fully cooperate with CMS-led evaluation, monitoring, and reporting requirements.

Legislative and Regulatory Action

Vermont's current state policy related to the "State policy actions" technical score factors and planned policy actions are described in the table below.[5]

Technical Score Factor	Vermont's Current State Policy	Commitment to Legislative or Regulatory Action and Timeline
Health and Lifestyle	Vermont has not implemented the Presidential Fitness Test as a mandate in schools.	None at this time.

[5] For legislative and regulatory actions specific to each initiative, see the **Initiatives and Use of Funds** section.

Technical Score Factor	Vermont's Current State Policy	Commitment to Legislative or Regulatory Action and Timeline
	The Vermont State Board of Education adopted the 2024 National Physical Education Standards to guide physical education curriculum development in 2024. These standards focus on building physical activity skills and knowledge over the public school years so that students will be life-long physical activity participants.	
SNAP Waivers	The state does not have any pending bills or regulation related to SNAP waivers at the time of this application submission.	The Governor has directed AHS to pursue submission of a USDA SNAP Food Restriction Waiver that will prohibit the purchase of non-nutritious items. The state will provide an update on the legislative timeline as part of continuing collaboration and will pursue completion of policy actions by the end of the CY 2027 to align with CMS guidelines.
Nutrition CME	The state does not have any pending bills or regulation related to Nutrition CME at the time of this application submission.	None at this time.
CON	Vermont has universal CON rules across all facility categories.[89] The state passed legislation in 2025 that increases the monetary thresholds at which a CON is required for a new health care project, purchase, or service. Under Act 15 (H.96), as of July 1st, 2025, a CON will be required for any construction, development, purchase, renovation, or other establishment of a health care facility, or any capital expenditure by or on behalf of a health care facility, for which the capital costs exceeds $10 million (previous limit was $1.5 million).[90]	No additional policy changes are planned at this time.
Licensure Compacts	Vermont participates in the following compacts[91]:	Vermont has fully enacted the IMLC but has not been able to

Technical Score Factor	Vermont's Current State Policy	Commitment to Legislative or Regulatory Action and Timeline
	• Audiology and Speech-Language Pathology Interstate Compact • Counseling Compact • Dietitian Compact • IMLC • Nurses Licensure Compact • Occupational Therapy Compact • Psychology Interjurisdictional Compact • Physical Therapy Compact • Social Work Licensure Compact The state does not yet participate in the EMS or PA Compacts [though legislation (H.572) was introduced in January 2024].	act as the State of Principal License because the Federal Bureau of Investigation has not yet approved the Board of Medical Practice to receive the criminal background reports necessary to confirm that an applicant has no disqualifying convictions and thus is eligible to be licensed in other states via the Compact. The Board of Medical Practice is working to get a technical amendment to Vermont law that may overcome Federal Bureau of Investigation concerns about the way the Vermont medical licensing law is structured. No further policy changes are planned at this time.

Scope of Practice	Vermont's scores related to practice authority are as follows:
	• PAs[92]: Advanced
	• NPs[93]: Full Practice
	• Pharmacists[94]:
	  ○ Overall: Improvements Needed
	  ○ Drug Administration: Full Authority
	  ○ Laboratory Testing: Improvements Needed, CLIA-Waived Authority
	  ○ Independent Prescribing: Improvements Needed, Formulary-Based Authority
	• Dental Hygienists[95]: Full Authority (except diagnosis)
		The state is planning to make changes to expand the pharmacist and EMS scope of practice per the initiatives described above.
		The state is also pursuing policy change to opt out of the Medicare supervision requirement for CRNAs.
		No additional scope of practice changes are planned at this time.

STLDI	STLDIs are restricted in the state.	None at this time.
Remote Care Services	Vermont has broad remote care policies for all modalities (e.g., live video, store and forward, RPM, audio-only) across Medicaid and private payers. The state has a telehealth license/registration process.[96]	None at this time.

Governance Structure and Project Management

AHS will lead the RHT Program and manage program administration and operations. (See the **Supporting Documentation, Exhibit 6** for more information about AHS and its departments.) The Secretary's Office will provide strategic leadership for the RHT Program. AHS may engage the subrecipient(s) supporting Initiative 1(transformation analytics and support) to support project management, particularly for the initial budget periods of the RHT Program performance period before transferring management to the state. As noted above, the state also plans to procure an independent evaluator to support clinical design and change management work related to specific initiatives. The governance, final headcount and functions of the team supporting the RHT Program are included in **Supporting Documentation**, **Exhibit 7**. Additional detail on costs associated with AHS staff positions is located in the **Budget Narrative**.

Optimizing collaboration within and across state government will be vital to the success of the RHT Program. The Agency's Health Care Reform Care Transformation Meetings, a cross-departmental AHS-led meeting series, will be leveraged by the Secretary's Office to ensure ongoing internal communication and operational support for the RHT Program, in partnership with relevant state agencies and partners, as needed (e.g., GMCB, DFR). To support effective internal coordination and oversight, AHS will leverage existing structures used to successfully manage large-scale, cross-departmental initiatives. These structures include a central coordination team with representatives from program, policy, and budget offices, and standardized processes for project reporting, budget management, and milestone monitoring.

AHS will develop a project charter that outlines the key aspects of the state's ongoing decision-making process for the RHT Program. The charter will describe the State of Vermont's functions in the RHT Program, RHT Program objectives, the roles of agencies and departments as part of

the state's agreement with CMS, and responsibilities and level of contributions of each entity to accomplish the goals of the RHT Program in alignment with CMS's requirements. The charter will also include a formal decision-making and accountability structure to ensure ongoing engagement and collaboration to meet RHT Program milestones and requirements.

Key agencies and partners that will have detailed roles in the charter will include AHS, the Governor's Office, the GMCB, the DFR, Agency of Commerce and Community Development (for housing-related initiatives) and others. AHS will collaborate with GMCB and DFR to inform program design and implementation, while the Governor's Office will provide oversight and strategic guidance for AHS's leadership of the program. Within AHS, roles and responsibilities will be delineated across the Agency, including the Vermont Department of Health and its Office of Rural Health, the DVHA, the Department of Mental Health, the Department of Disabilities, Aging and Independent Living, and the Office of Health Care Reform.

Stakeholder Engagement

Given the statewide nature of the RHT Program, AHS will coordinate and communicate closely with a wide variety of state agency, health system, and community stakeholders throughout the Program's implementation timeline. AHS has consulted the following stakeholders to shape the state's RHT Program application narrative and transformation plan (non-exhaustive list):

Key Stakeholders
• Federal Delegation Staff • Legislators (i.e., Health Reform Oversight Committee, Joint Fiscal Office, Legislative Counsel) • Governor's Office • Department of Taxes • Department of Financial Regulation • Agency of Agriculture, Food, and Markets • Agency of Education • Agency of Commerce and Community Development • GMCB • Office of the Healthcare Advocate

Key Stakeholders
• Medicaid Advisory Committee • Vermont Medical Society • Vermont Dental Society • Vermont Program for Quality in Health Care • Bi-State Primary Care Association • Vermont Healthfirst • Vermont Care Partners • Vermont Association of Hospitals and Health Systems • Vermont Hospital Chief Executive Officers and leadership teams

AHS plans to leverage the following, existing advisory committees to formally engage key stakeholders on a regular basis as part of RHT Program:

Vermont Steering Committee for Comprehensive Primary Care	A 16-member committee, which convenes every other month, comprised primarily of primary care providers. The committee's primary task is to work with state government, including the Blueprint for Health and the Office of Health Care Reform in the AHS, as it relates to access to, delivery of, and payment for primary care services in Vermont.
Health Care Delivery Advisory Committee	An 18-member committee, which convenes on a quarterly basis, focused on transforming Vermont's health care system. Members include the following: • Key representatives from AHS, GMCB, and the Office of the Health Care Advocate. • Members from Vermont's health care sectors, including hospitals, health centers, insurers, and various health care professionals. • Representatives from small businesses and long-term care facilities.
Note: Agendas, minutes, and materials from these Committees meetings are public. These committees are also required to provide an opportunity for public comment.	

These advisory committees reflect a wide variety of health care communities (e.g., providers payers, advocates, etc.) with a direct connection to the RHT Program and its initiatives. AHS will also leverage existing patient-facing groups, such as the state's Medicaid Advisory Committee (run by DVHA), and the Office of the Health Care Advocate, to solicit feedback on the RHT Program's initiatives. AHS has existing offices and communication channels within the state in order to communicate directly with the state's tribal residents to solicit feedback. Vermont has a successful history of working closely with tribal communities as part of previous grants and will consult these lessons learned for this funding opportunity.[97]

AHS established a Health Care Transformation website to communicate with the broader public and share updates related to the state's work implementing the RHT Program.[98] The website includes a contact form, which will be kept open throughout the length of the state's award as an opportunity for the public to submit ongoing comments and questions. AHS will field and respond to all submissions, funneling relevant insights and feedback through the Health Care Reform Care Transformation Meeting series and committees described above, as applicable. In addition, AHS will update the website with relevant reports and materials as a resource for the broader public to stay informed about RHT Program implementation in the state. AHS is committed to transparency and frequent communication through its internal and external channels to ensure the successful implementation of the RHT Program.

Appendix
List of Supporting Documentation

- Exhibit 1. Population by County, Town, Gender, and Age
- Exhibit 2. RHT CCBHC Data Submission
- Exhibit 3. Health Care Access Drive Times
- Exhibit 4. Primary Care Practices by RSA
- Exhibit 5. FY26 Approved Hospital Budgets
- Exhibit 6. AHS Organization Structure and Functions
- Exhibit 7. VT RHT Program Governance Model
- Exhibit 8. Vermont Provider Association Letter of Support

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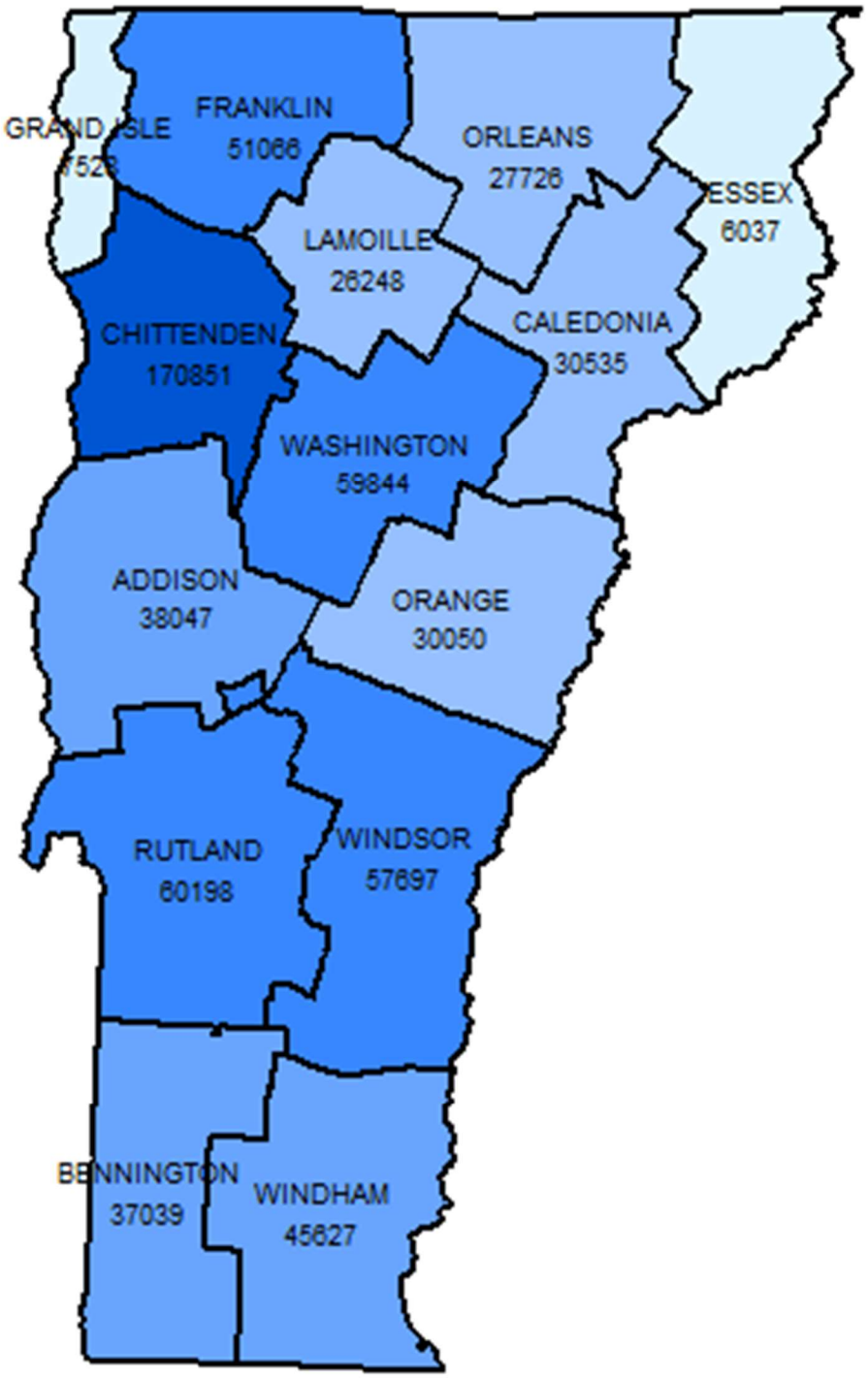
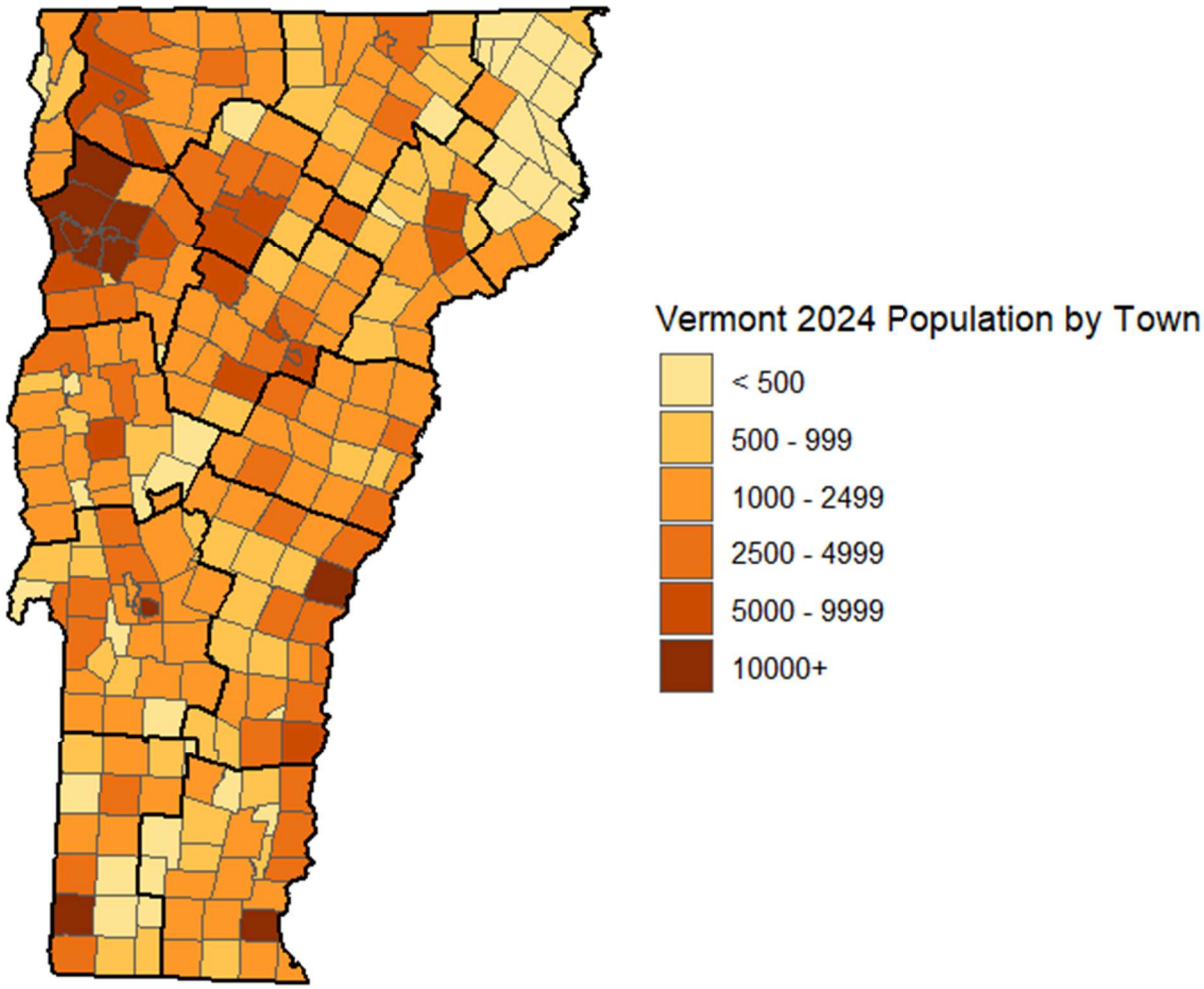
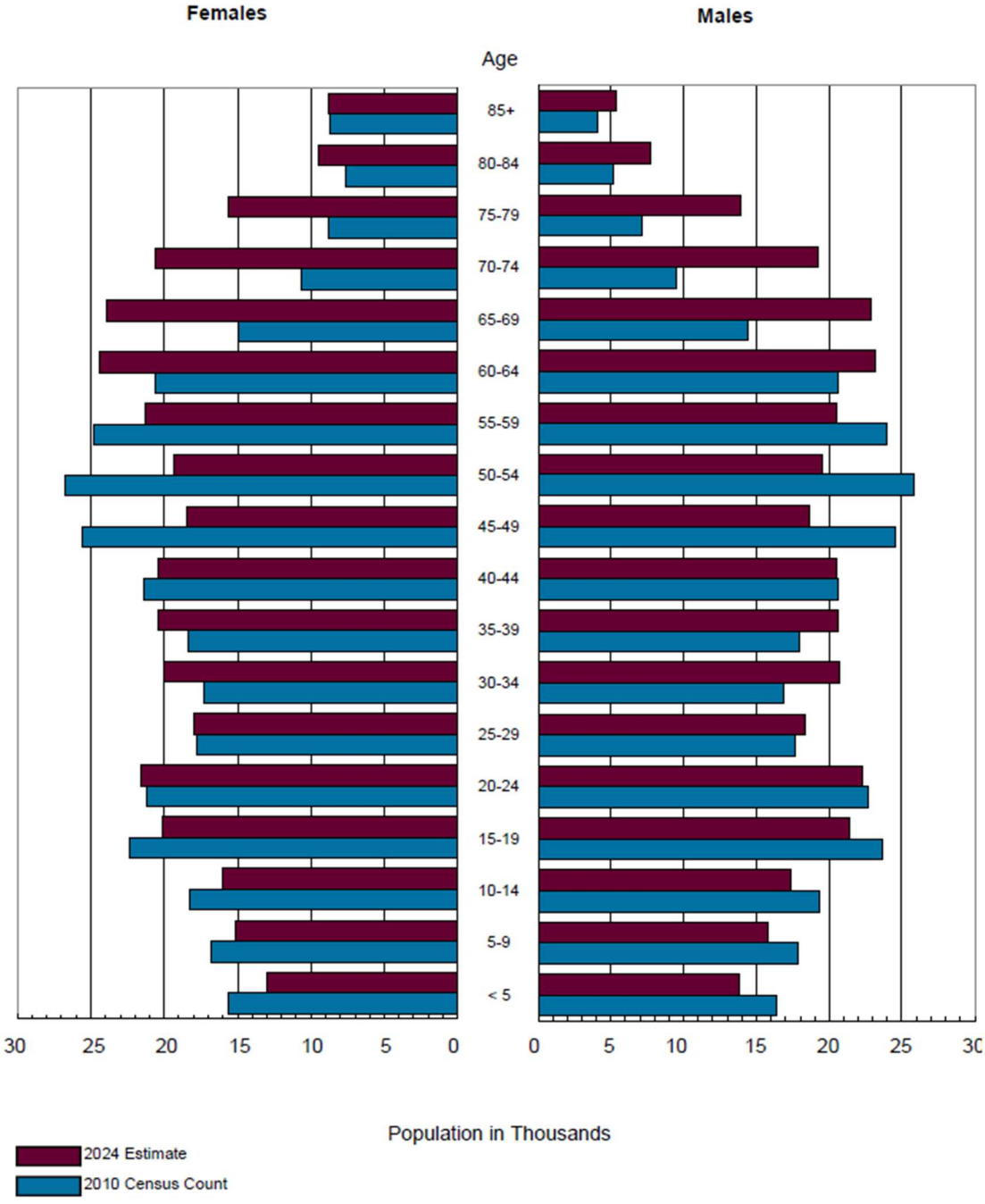




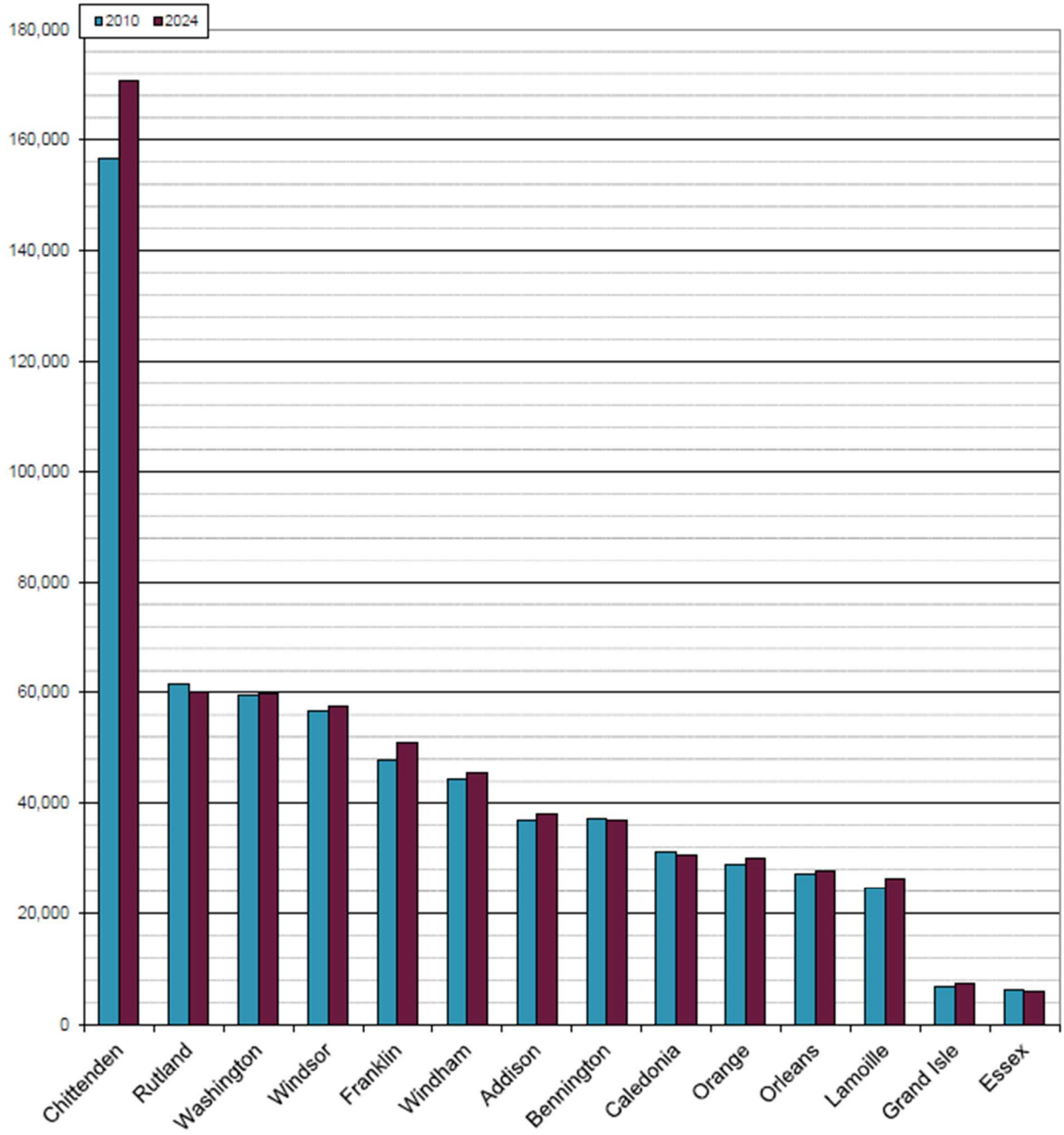
2024 Vermont Population Estimates

healthvermont.gov

Population Age-Sex Distribution of Vermont, 2010, 2024.

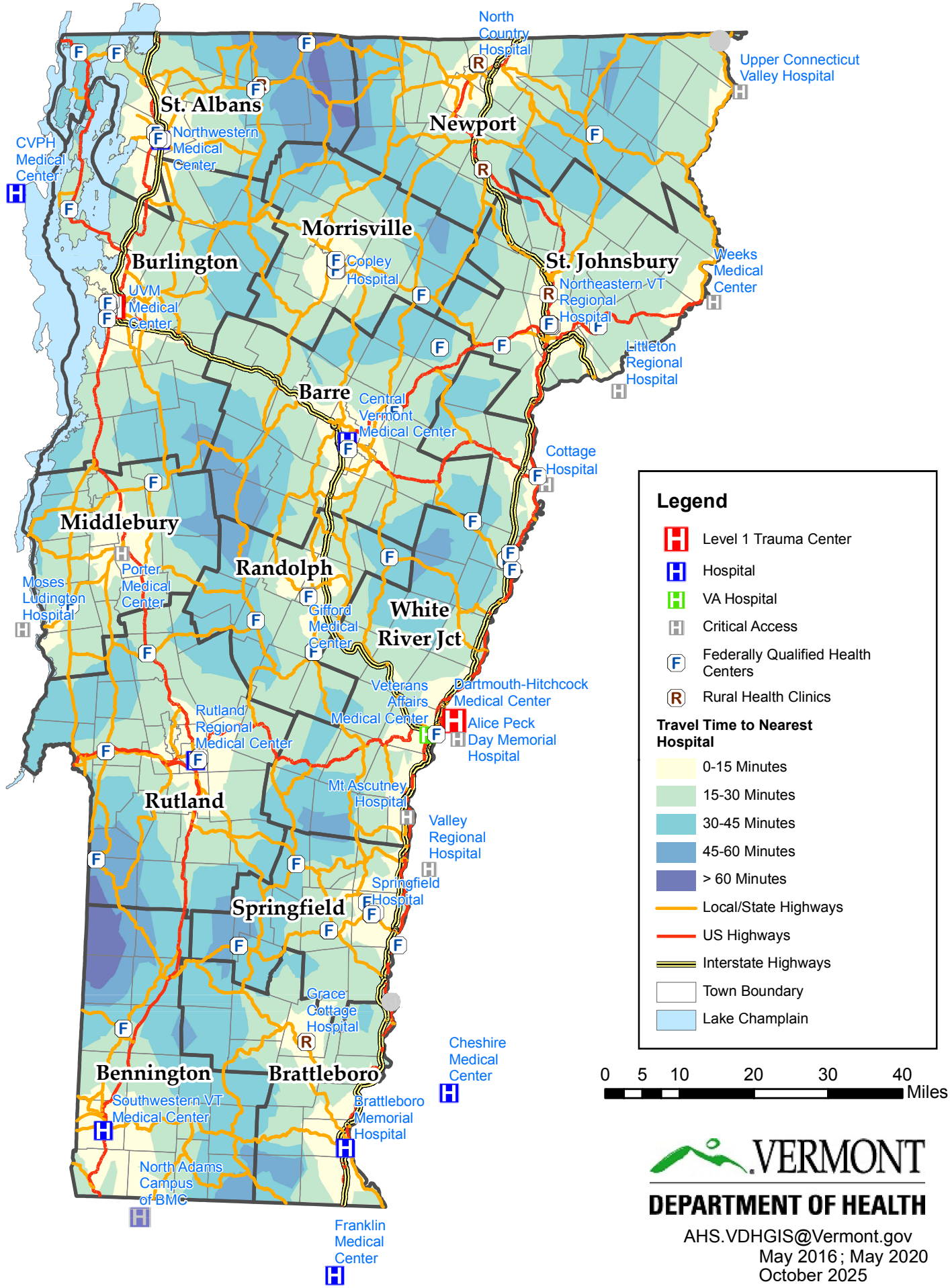


Population of Vermont Counties
2010 Census Counts and 2024 Estimates



Active Site of Care Name	Street Address	City	State	ZIP Code	Corresponding CCBHC Entity/Institution Name	Demonstration	State-certified	SAMHSA	HRSA Rurality (Y/N)
Clara Martin Center	11 North Main Street	Randolph	VT	05060	Clara Martin Center	Y	Y	Y	Y
24 South Main	24 South Main Street	Randolph	VT	05060	Clara Martin Center	Y	Y	Y	Y
Bradford Main Site	1483 Lower Plain	Bradford	VT	05033	Clara Martin Center	Y	Y	Y	Y
Bradford Farmhouse	1740 Lower Plain	Bradford	VT	05033	Clara Martin Center	Y	Y	Y	Y
	78 South Main Street	Rutland	VT	05701	Community Care Network, Rutland Mental Health Services	Y	Y	Y	Y
	7 Court Square	Rutland	VT	05701	Community Care Network, Rutland Mental Health Services	Y	Y	Y	Y

Rural Health Clinics, Federally Qualified Health Centers & Hospitals by Hospital Service Areas & Travel Time to Nearest Hospital



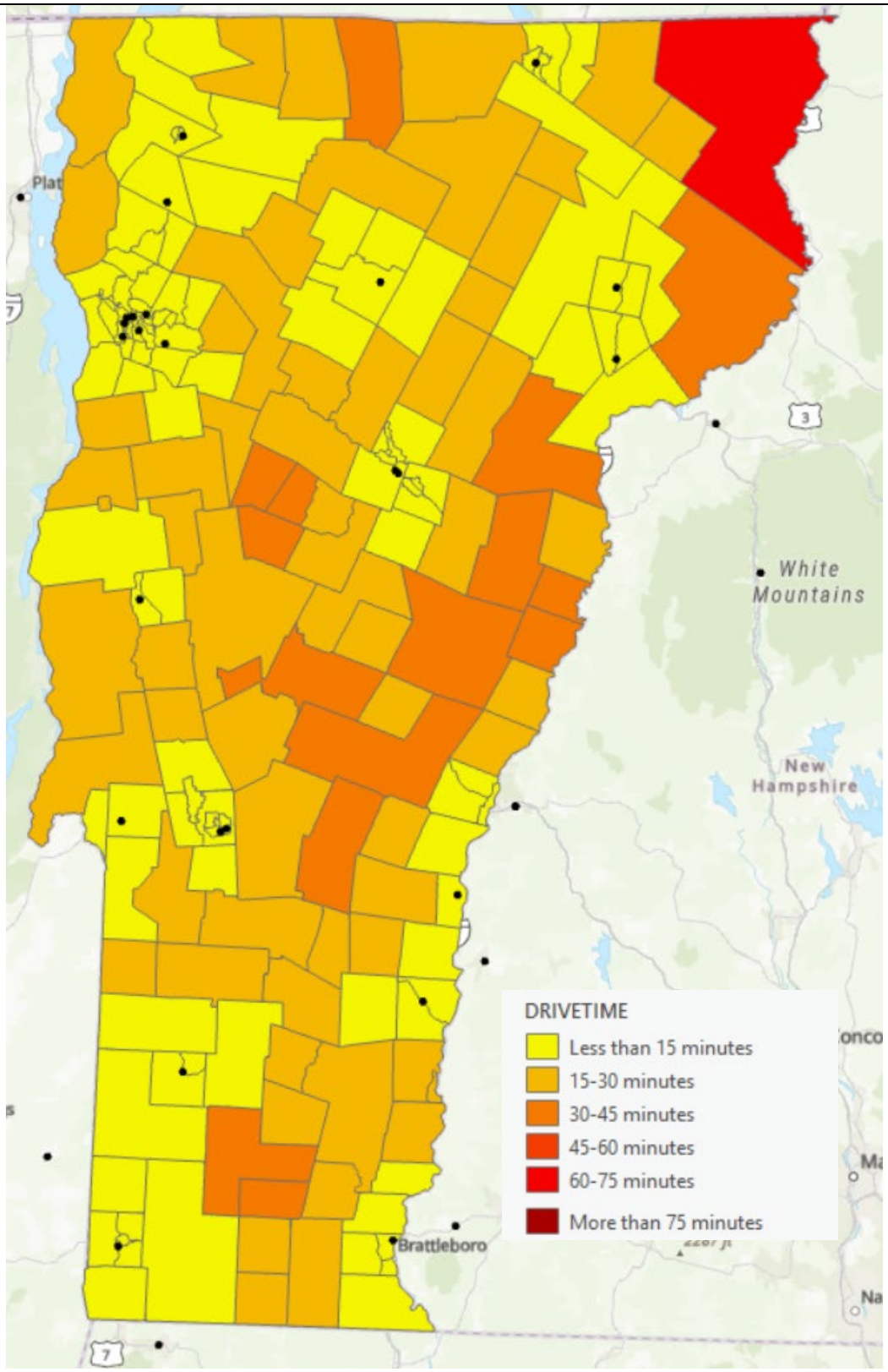
VERMONT
DEPARTMENT OF HEALTH

AHS.VDHGIS@Vermont.gov

May 2016 ; May 2020
October 2025

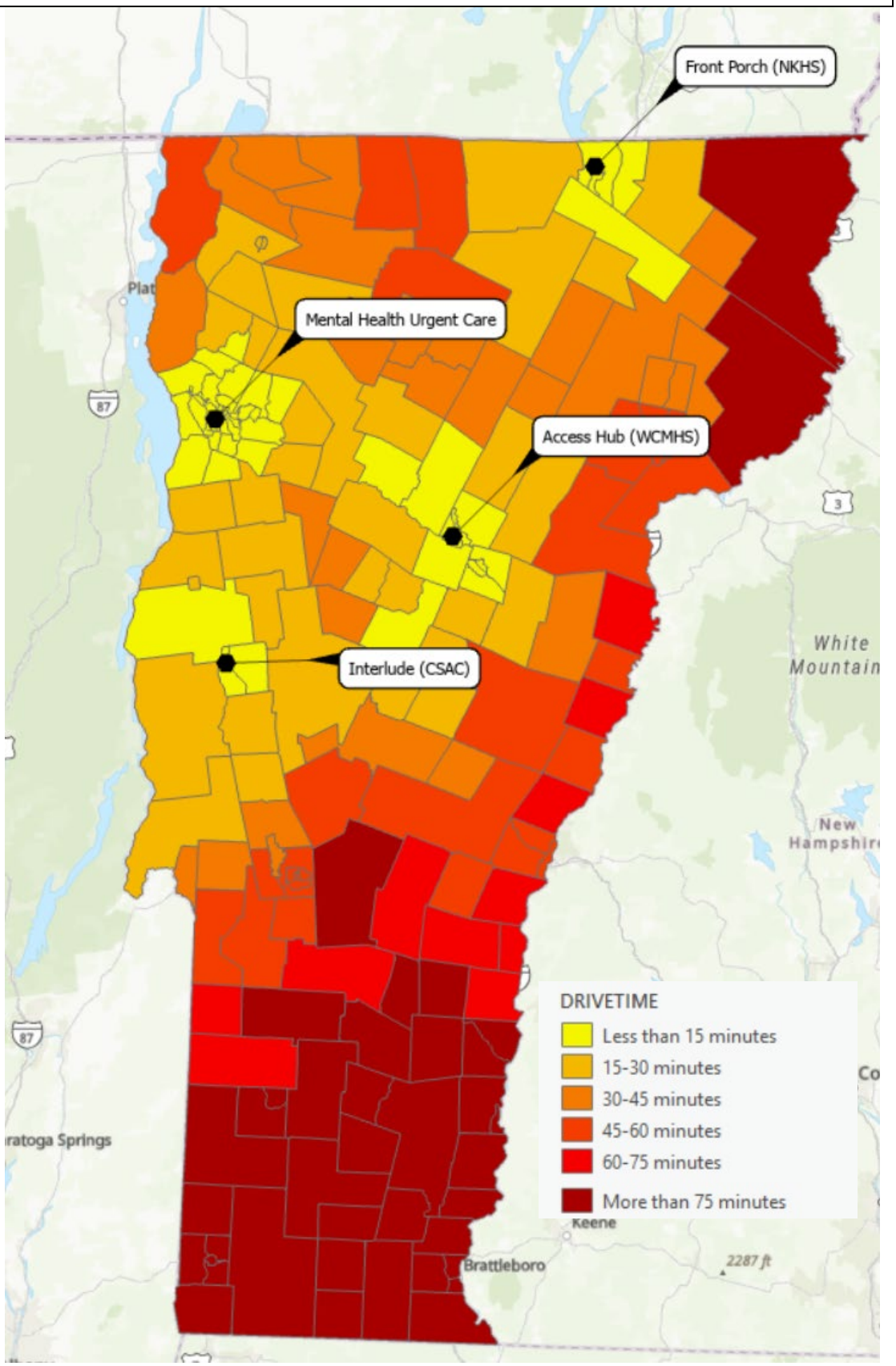
URGENT CARE LOCATIONS AND DRIVE TIMES

Includes all locations that note “Urgent Care,” “Express Care,” or “Walk-In Appointments” within Vermont or adjacent counties. Excludes FQHC locations without walk-in option.



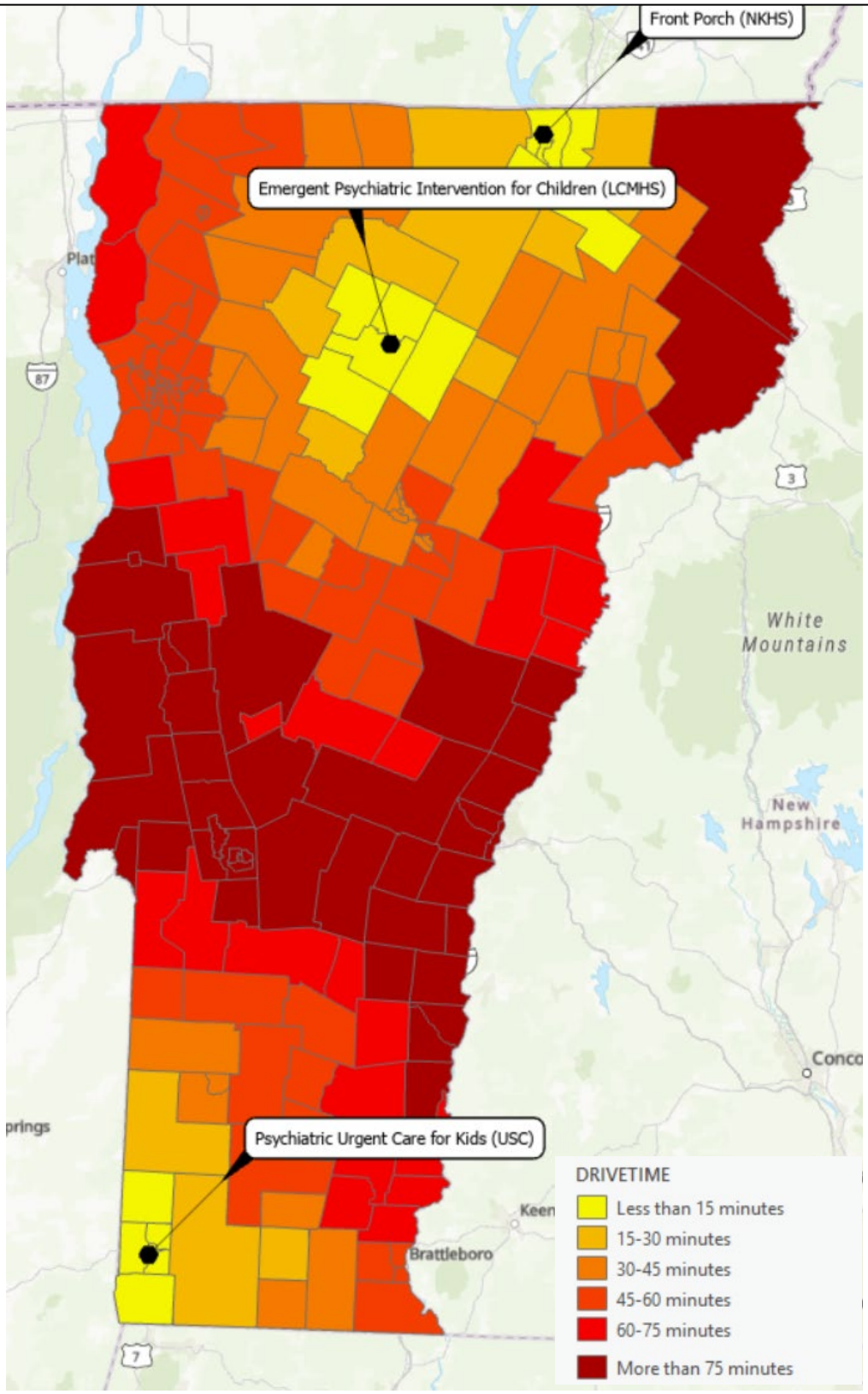
MENTAL HEALTH URGENT CARE (ALT TO ED) LOCATIONS - ADULTS

As designated in DMH's Mental Health Response Service Guidelines



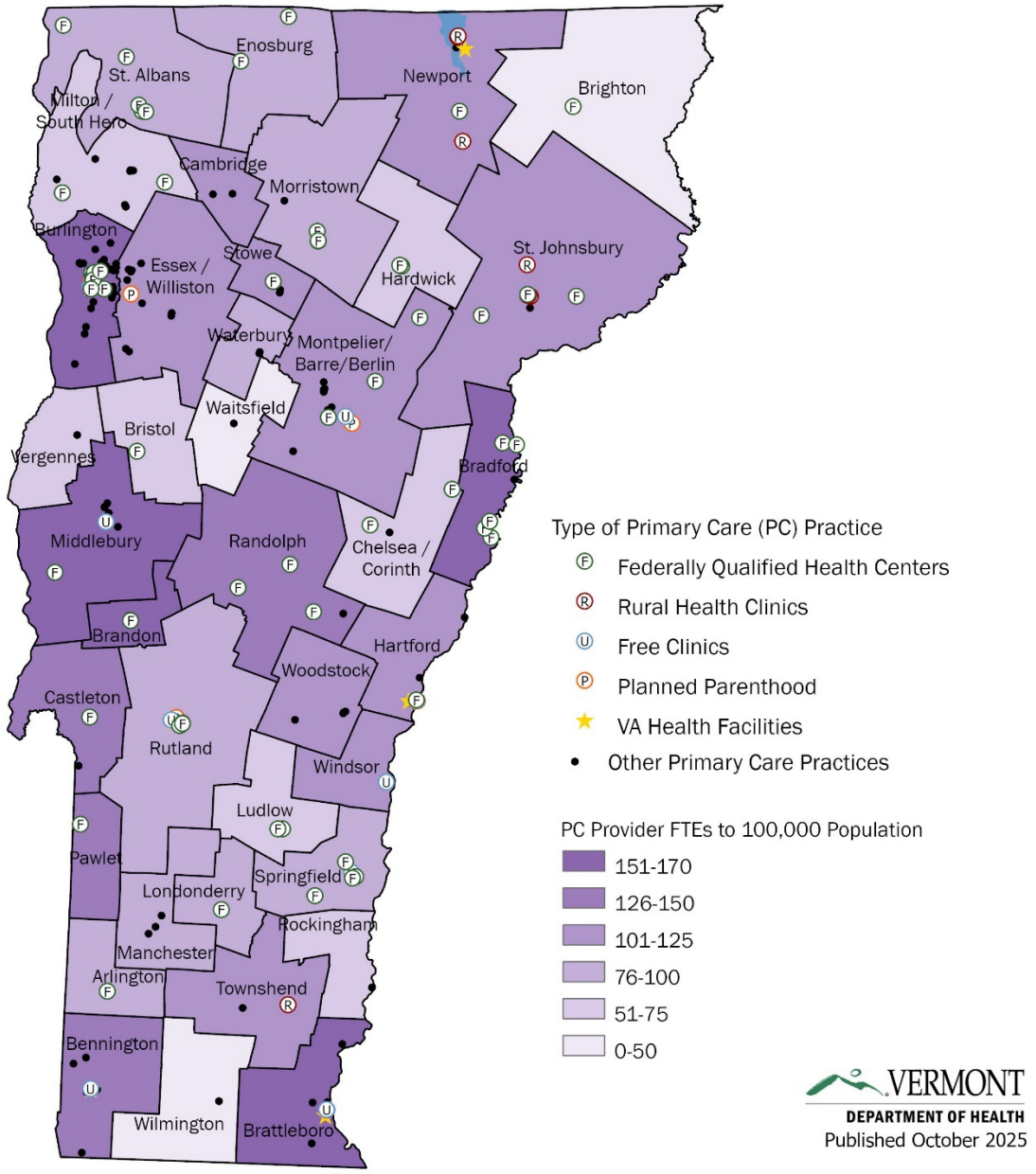
MENTAL HEALTH URGENT CARE (ALT TO ED) LOCATIONS - YOUTH

As designated in DMH's Mental Health Response Service Guidelines



Map of Rational Service Areas (RSAs) that Reflect Primary Care-Seeking Patterns

Primary Care (PC) Practices by Rational Service Area (RSA)



Vermont Department of Health, Health Care Provider Census (MDs/DOs (2022), PAs (2022), and APRNs (2023)
FQHC locations – Bi-State Primary Care Association
RHC, PPNNE, Free Clinic locations - Vermont State Office of Rural Health
Other PC practice locations – Vermont Blueprint for Health

PC Provider FTEs (full-time equivalents) include Physicians, Physician Assistants & Nurse Practitioners providing primary care.
FTE ratios only include providers in locations open to the public, and exclude facilities offering only outpatient services, telehealth or urgent care services. Locum tenens providers are also excluded.
Locations shown as Other PC practices include independent practices, hospital-owned practices and group practices.
Rational Service Areas (RSAs) are groupings of towns reflecting where people receive care based on data from Medicare and Medicaid claims and Vermont's Behavioral Risk Factor Surveillance System (BRFSS).

Notes

- The map shows 38 Rational Service Areas (RSAs) that reflect primary care-seeking patterns.
- These RSAs are used for our Health Professional Shortage Area (HPSA) designation process for PC and Dental.
    - Shading for FTEs:100,000 population – combining FTEs for PC Physicians (2022), PAs (2022) and APRNs (2023)
- Ratios standardize relative service or under-service across different geographies
- Primary care locations are from Blueprint, VDH, Bi-State, etc.
    - Icons for FQHCs (49), RHCs (10), Free & Referral Clinics (10), Veterans Affairs clinics (6), and
    - Dots for Other PC Practices owned by hospitals (50), multi-site groups (30), and independent practices (69)
    - Multiple PC practices may be located near enough that their dots / icons overlap visually.

	Commercial Rate			Net Patient Revenue Cap				Commercial Net Patient Revenue Cap				Operating Expenses			
Hospital	Hospital Proposed	Approved	Δ%	Hospital Proposed	Approved	Δ$	Δ%	Hospital Proposed	Approved	Δ$	Δ%	Hospital Proposed	Approved	Δ$	Δ%
Brattleboro Memorial Hospital	3.0%	2.4%	-0.6%	115,415,847	113,499,959	-1,915,888	-1.7%	34,698,710	32,782,822	-1,915,888	-5.5%	121,108,874	119,192,986	-1,915,888	-1.6%
Central Vermont Medical Center	3.0%	2.9%	-0.1%	301,705,016	301,641,023	-63,993	0.0%	156,320,994	156,257,001	-63,993	0.0%	317,894,060	317,830,067	-63,993	0.0%
Copley Hospital	4.2%	3.0%	-1.2%	129,637,240	128,904,314	-732,926	-0.6%	60,954,720	60,221,794	-732,926	-1.2%	127,856,556	127,856,556	0	0.0%
Gifford Medical Center	3.0%	3.0%	0.0%	65,060,532	65,060,532	0	0.0%	29,175,160	29,175,160	0	0.0%	65,721,059	65,721,059	0	0.0%
*Grace Cottage Hospital**	*0.0%*	*0.0%*	*0.0%*	*30,201,165*	*30,201,165*	*0*	*0.0%*	*7,777,865*	*7,777,865*	*0*	*0.0%*	*32,408,481*	*32,408,481*	*0*	*0.0%*
Mt. Ascutney Hospital & Health Ctr	3.0%	3.0%	0.0%	75,343,734	75,343,734	0	0.0%	25,402,822	25,402,822	0	0.0%	80,643,414	80,643,414	0	0.0%
*North Country Hospital**	*0.5%*	*0.5%*	*0.0%*	*107,314,867*	*107,314,867*	*0*	*0.0%*	*53,124,632*	*53,124,632*	*0*	*0.0%*	*110,896,623*	*110,896,623*	*0*	*0.0%*
*Northeastern VT Regional Hospital**	*3.0%*	*3.0%*	*0.0%*	*131,373,037*	*131,373,037*	*0*	*0.0%*	*64,029,182*	*64,029,182*	*0*	*0.0%*	*135,466,166*	*135,466,166*	*0*	*0.0%*
Northwestern Medical Center	2.6%	2.6%	0.0%	130,887,475	130,887,475	0	0.0%	83,700,251	83,700,251	0	0.0%	146,596,865	146,596,865	0	0.0%
Porter Medical Center	3.0%	2.9%	-0.1%	134,850,642	134,821,993	-28,649	0.0%	68,297,072	68,268,423	-28,649	0.0%	131,967,684	131,939,035	-28,649	0.0%
Rutland Regional Medical Center	1.5%	1.5%	0.0%	336,642,584	336,642,584	0	0.0%	165,151,422	165,151,422	0	0.0%	362,432,388	362,432,388	0	0.0%
Southwestern VT Medical Center	5.2% (Orig. 2.7%)	3.0%	-2.2%	218,054,234	214,723,065	-3,331,169	-1.5%	99,253,903	95,922,734	-3,331,169	-3.4%	230,491,761 (Orig. 231.4M)	230,491,761	0	0.0%
Springfield Hospital	3.0%	3.0%	0.0%	69,804,489	69,804,489	0	0.0%	33,449,140	33,449,140	0	0.0%	70,578,940	70,578,940	0	0.0%
The University of Vermont Medical Center	2.4%	-6.4%	-8.9%	1,986,591,292	1,898,078,939	-88,512,353	-4.5%	1,157,427,345	1,068,914,992	-88,512,353	-7.6%	2,347,880,836	2,347,415,128	-465,708	0.0%
Total VT Community Hospitals	**2.6%**	**-2.0%**	**-4.7%**	**3,832,882,154**	**3,738,297,176**	**-94,584,978**	**-2.5%**	**2,038,763,217**	**1,944,178,240**	**-94,584,978**	**-4.6%**	**4,281,943,707**	**4,279,469,469**	**-2,474,238**	**-0.1%**

**Exempt from hearings; approved as submitted*

Total commercial revenue in Adaptive less Medicare Adv.

AHS Structure

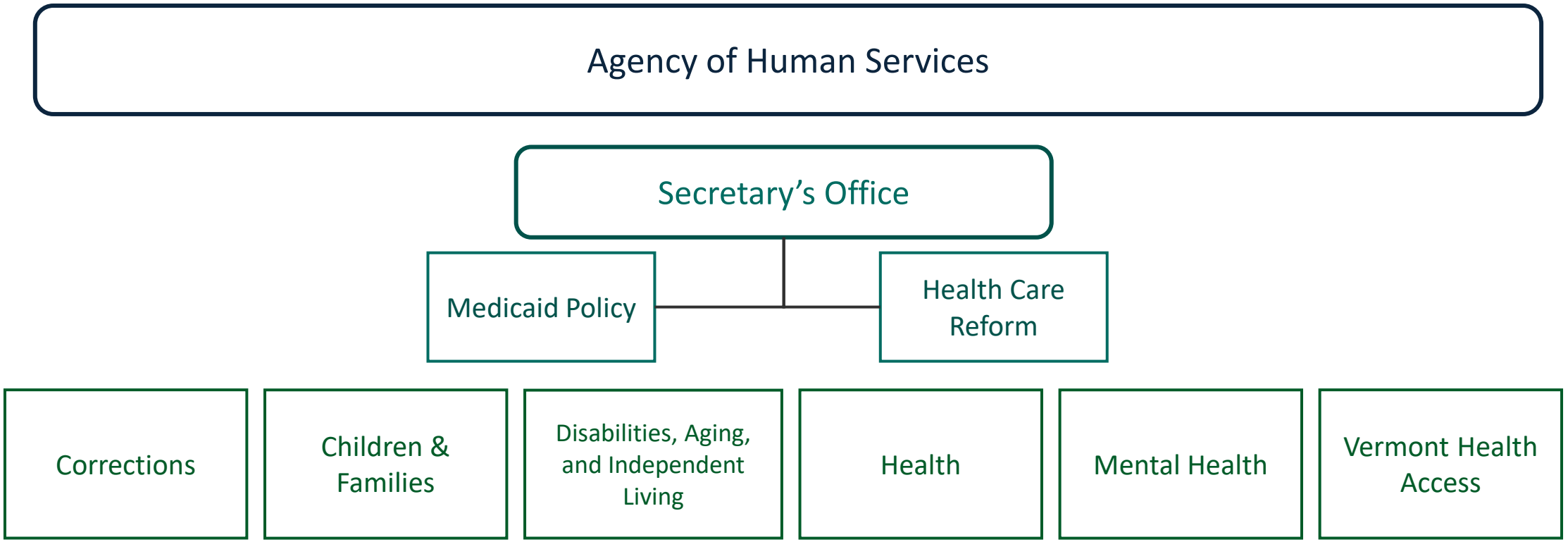
The Agency of Human Services has six Departments and a Central Office (Secretary's Office).

The Secretary's Office includes the Medicaid Policy Unit and the Office of Health Care Reform, which encompasses the Blueprint for Health program, Vermont Chronic Care Initiative, Field Services Directors, Health Data Unit, Healthcare Workforce Development Team, and Care Transformation Team.

Department	Mission
Department of Aging, Disabilities, and Independent Living (DAIL)	Make Vermont the best state in which to grow old or live with a disability – with dignity, respect, and independence.
Department for Children and Families (DCF)	Foster the healthy development, safety, well-being, and self-sufficiency of Vermonters.
Department of Corrections (DOC)	Support safe communities by providing leadership in crime prevention, repairing harm done, addressing needs of crime victims, ensuring offender accountability, and managing risk posed by offenders.
Department of Mental Health (DMH)	Promote and improve the health of Vermonters.
Department of Vermont Health Access (DVHA)	Improve overall access, quality, and affordability of health care and to assist Medicaid members in Vermont.
Vermont Department of Health (VDH)	Protect and promote the best health for all Vermonters.

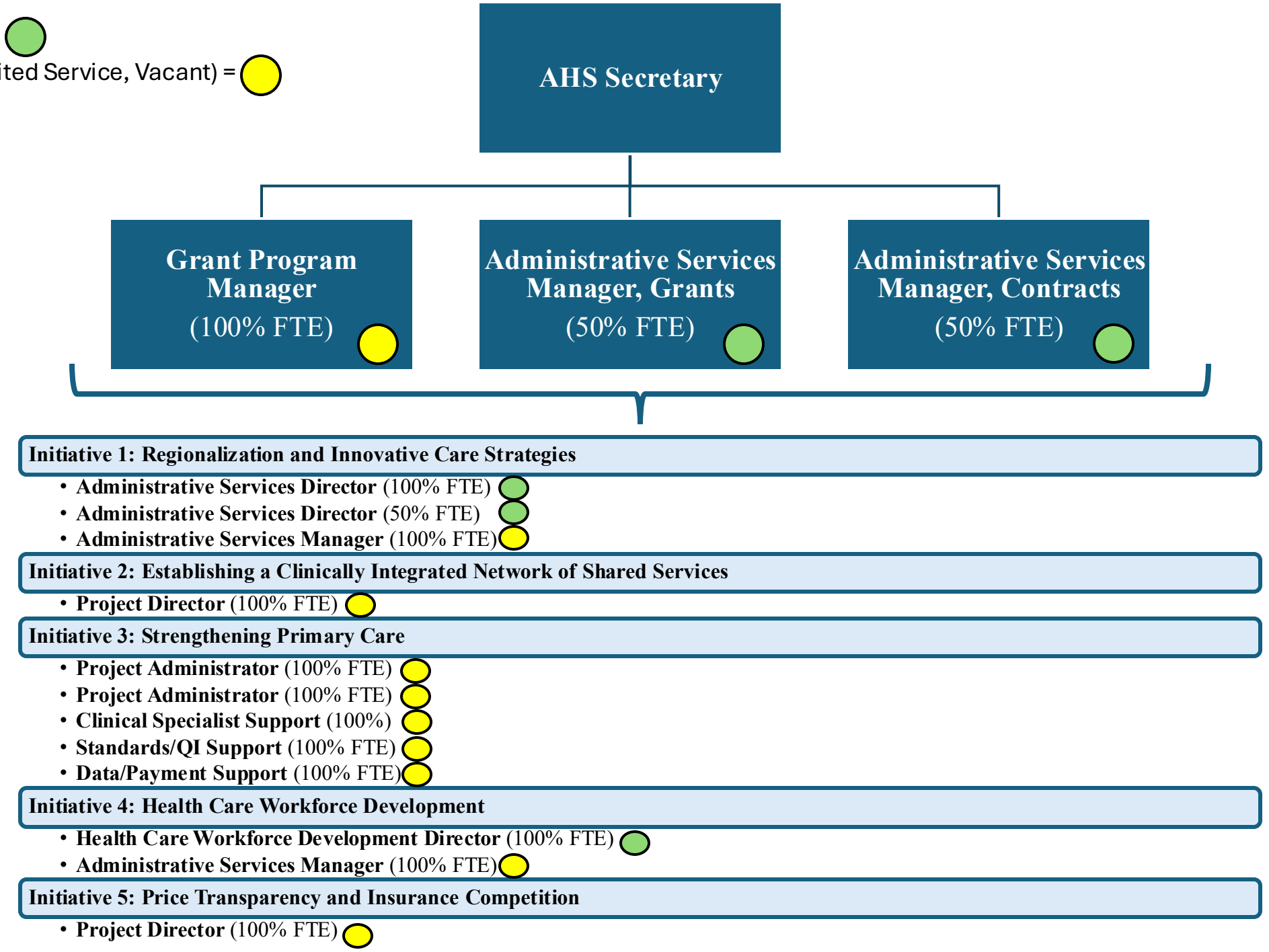
VERMONT
AGENCY OF HUMAN SERVICES

AHS Structure



VERMONT
AGENCY OF HUMAN SERVICES

Key:
Current Employee =
New Employee (Limited Service, Vacant) =



Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Subject: Health Care Provider Associations Letter of Support – CMS Rural Health Transformation Program, State of Vermont

Dear Administrator Oz:

On behalf of the undersigned health care associations, please accept this letter of support for Vermont's application to the Centers for Medicare & Medicaid Services (CMS) for the Rural Health Transformation Program (CMS-RHT-26-001).

We represent a wide range of health care providers across Vermont and write to express our strong support for Vermont's plan to improve our state's rural health care system and population health through this funding opportunity. Due to our small and rural nature, Vermont faces a variety of challenges as it relates to rural health care delivery and population health needs. However, we are also well positioned to address these challenges through the RHT Program opportunity. In particular, our organizations support Vermont's RHT Program initiatives related to continuing our state's efforts to regionalize and optimally distribute health care resources; achieve scale and operational efficiencies through shared clinical services; incentivize adoption of telehealth, remote patient monitoring and artificial intelligence technologies; strengthen primary care and the rural health care workforce; and improve health care transparency and affordability.

Due to our small size, our state also benefits from the ability to maintain close partnerships and strong collaborations. Our organizations stand ready to work together with the state to implement the initiatives in the state's application to collectively strengthen our rural system of care.

Thank you for considering our letter of support for this critical funding opportunity to improve care for rural Vermonters.

Sincerely,

Jessa Barnard

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